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ABSTRACT

This manual is intended to help professionals and non-professionals develop a peer support system involving older persons in the provision of comprehensive mental health services. The materials focus on: (1) program concept and objectives; (2) links between physical and mental health in the elderly; (3) recruitment and training of peer counselors; (4) health education workshops; (5) support networks; and (5) program evaluation. The first section presents the history, background, and description of the program along with the rationale for its development. The second section provides specific guidelines for developing and adapting the program to fit the special characteristics of each community. A basic premise of this manual is the involvement of older persons in all phases of program development. (Author/JAC)

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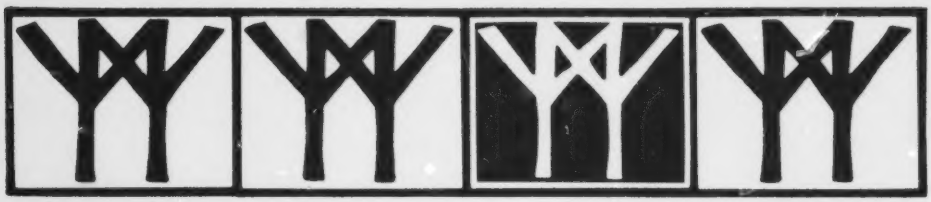

FOR OLDER ADULTS

A Manual for Replication

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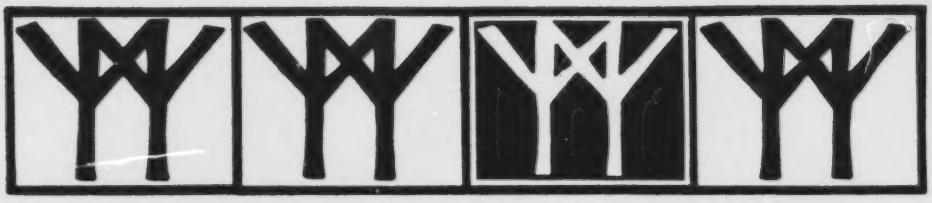

FOR OLDER ADULTS

A MANUAL FOR REPLICATION

by

Ruth Campbell and
Barbara Chenoweth
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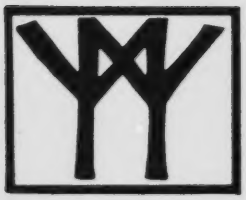

This symbol dates from before the Middle Ages and represents the support of friendships outside the family circle.

@ January 1981, The University of Michigan, Ann Arbor, Michigan.

This manual is dedicated to the peer counselors whose wisdom, patience, energy, and humor continues to instruct and amaze us. We proudly share with them the achievements of our program. The support they have given to their peers, they have also given to us.

Turner Clinic

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INTRODUCTION

The Peer Support System started in 1978 as part of the psychosocial component of the Turner Geriatric Clinic, an out-patient clinic at The University of Michigan Hospital in Ann Arbor, Michigan. It began as a program of monthly health education workshops planned and implemented by a group of peer counselors. Since then, under a grant from the Administration on Aging (AoA), Model Projects, the health education/peer counselor program has been demonstrated in three other locations, and the Turner Clinic program has expanded to include a wide range of small support groups and individual counseling. As of September 1980, 48 older men and women have been trained as peer counselors and approximately 2,500 people have participated in some phase of the program.

This manual was written to describe our model for providing education and counseling to older adults in a way that is responsive to their varying needs, experiences, and skills. The topics covered include:

A description of the Turner Geriatric Clinic;

A discussion of the links between physical and mental health in the elderly and their relevance to programming;

An overview of the Peer Support System;

Peer Counselors: Recruitment, training, and responsibilities;

The Health Education Workshops;

The Network Effect: Small support groups, individual counseling, and information and referral;

Evaluation.

We hope this manual will be useful to both professionals and non-professionals working in the health and mental health fields with older adults. In order to make it easier to use, we have organized it into two sections: Section I presents

the history, background, and description of the program along with the rationale for its development; Section II presents specific guidelines to be used for replicating each portion of the program. The guidelines are to be used as a starting point and adapted to fit the special characteristics of each community. Our emphasis on involving older people in all phases of the project, from initial planning through evaluation, is appropriate in a variety of settings. If this manual stimulates ideas and opens new areas for exploration of the talents of older adults, we will have accomplished our purpose.

SECTION I

THE TURNER GERIATRIC CLINIC

The Peer Support System grew out of the introduction of the Turner Geriatric Clinic to the community. Inaugurated in September 1977, the Clinic was constructed as the result of a bequest from the Scott and Amy Prudden Turner estate. Since then, subsidization from University Hospital and The University of Michigan Medical School's Department of Internal Medicine has maintained the Clinic's medical program.

Designed as an out-patient clinic for ambulatory persons 60 years of age and older, the Clinic provides both comprehensive health assessment and ongoing care. As of September 1980, 892 new patients have been served, with a total of 3,183 patient visits. About half the total patients regard the Clinic as their primary source of care. For the remainder, the Clinic functions as a consultation resource for agencies or for physicians practicing in the community.

The average Turner Clinic patient has a list of six to twelve problems requiring attention. The assessment procedure begins with a questionnaire, completed at home by the patient, covering general health status. At the first appointment, this information is reviewed, expanded upon as required, and supplemented with a complete physical evaluation. The first visit may take up to two hours. Defined problems are then prioritized and the staff, patient, and involved family members or friends discuss the patient's needs and arrange for ongoing comprehensive care in the Clinic or elsewhere. Patients are encouraged to return for annual evaluations as well as for interim visits as indicated. If a patient is referred for consultation to another University Hospital clinic, reports and laboratory results are coordinated by Clinic staff and discussed with the patient.

The full-time staff includes an internist, a nurse clinician, a social worker, a clerk, and a secretary. Part-time staff consists of two psychiatrists, a nutritionist, a physical therapist, two gynecologic nurse clinicians, and an audiologist, some of whom are volunteers. In addition, the Clinic offers an opportunity to students in medicine, nursing, pharmacy, social work, gerontology, audiology, public health,

physical education, and psychology to work with the elderly. In all areas of service the Clinic has been characterized by innovation and research into better ways of helping people with chronic problems.

From the beginning, the Clinic emphasized the importance of nonmedical influences on a patient's health. The total environment of the patient--involvement of family, friends and neighbors, housing, nutrition, the patient's daily activities and needs, recent losses and changes in the patient's life, mobility--were taken into consideration. It soon became clear that the elderly population represented a wide range of people with varying and changing needs extending from informational services and preventive medicine through acute care and crisis intervention. The Clinic staff also recognized their responsibilities as educators to the community by disseminating medical and psychosocial information that would help older people function as independently as possible.

Gradually an integrated set of health-related support services developed, available to Clinic patients and nonpatients as well. This multi-level program combines the expertise of Clinic staff with resource persons in the community. It offers referral services, individual and family counseling, informational workshops and a series of small support groups. The program is flexible and responsive to community needs. Thus, linking traditional medical care with support services improves care for individual patients and provides a link to the community and the resources it has to offer.

BACKGROUND OF THE PEER SUPPORT SYSTEM

The links between mental and physical health and the effects that life crises can have on both, have received increasing attention. Developing simultaneously is the growing interest in self-care; the "informed" patient seeks information about prevention as well as treatment, the side-effects of drugs, and the benefits of nutrition and exercise. As Butler and Lewis (1977), among others, have noted, these ideas have particular relevance in old age when the relationship between physical and mental health is the most complex. Yet aside from snippets of information in the press and on television, systematic and reliable sources of information are not readily available.

Physical health as a major concern of the elderly has been well documented. Although 75 percent of older people describe themselves as well, 86 percent have one or more chronic conditions and 39.4 percent are limited in major activities (National Center for Health Statistics, 1977). While about 11 percent of the population is over 65 years of age, this group consumes 27 percent of the health dollar (Lesnoff-Caravaglia, 1980). The prevalence of chronic illness, compounded by its potential for causing major life disruption, sets up conditions which require more than medical treatment for resolution. An 80 year old man, otherwise in good health, worries about his gradually failing vision while fearing the risk of the cataract operation recommended by his physician. Yet he knows that if he refuses surgery, he very likely will have to stop driving. "It is to the physician, not the psychiatrist, that the old and their families turn to for crisis intervention," says Alex Comfort (1980), but the physician is necessarily limited in the kind of support he/she can offer.

Program Description

The Peer Support System was initiated in 1978 at the Turner Geriatric Clinic to complement the medical program with psychosocial support for the elderly and their families. As a new out-patient clinic of The University of Michigan, the Clinic offered complete health assessment and diagnosis along with ongoing health care for anyone 60 years of age and

older. Since the Clinic saw a responsibility to make its services available to the community, the Peer Support System programs were open to nonpatients as well. The objectives were to involve older people in the provision of mental health services, including health education, and to coordinate with existing community agencies. The basic program consisted of (1) recruiting and training peer counselors and (2) conducting monthly health education workshops.

Funding from the Administration on Aging made it possible to demonstrate the project in four different sites: the health care clinic, a senior nutrition site, a nursing home, and a community hospital in a rural area. During a two year period, 48 peer counselors developed programs which accounted for approximately 5,000 participant contacts. This included 43 educational workshops, 34 small group programs, 4 peer counselor groups, peer counselor clients, telephone consultations, 2 annual picnics and 1 health fair. The original plan of peer counselors organizing and implementing monthly health education workshops quickly expanded into a support network based on the skills and interests of the peer counselors and the needs presented by their contemporaries.

Social Support Networks

Walker, McBride and Vachon (1977) defined support networks as "... that set of personal contacts through which the individual maintains his social identity, and receives emotional support, material aid, services, information, and new social contacts." The major role of the family in providing this kind of support has been well documented (Sussman, 1976; Lowenthal and Robinson, 1976; Brody, 1980). Others have shown that a special friend can also fulfill this role (Blau, 1961; Lowenthal and Haven, 1968). Pilsuk and Minkler (1980) described six supportive network systems, two of which were health oriented, and concluded that "intentional, extra-kinship network development may play an increasingly important role on health maintenance." What seems clear is that families cannot be the only source of support for the growing number of people over 75 years of age without increasing the strain on adult children. Moreover, a sizeable number of the elderly do not live near their children or have no children.

As Kahn and Antonucci (1979) summarized numerous studies on the effects of social support on health, they found ample evidence that support networks exerted a moderating effect on stress, including the stresses of aging. Although widowed persons were reported to have an increase in health problems during the first six months of bereavement, a study by Raphael (1977) found that widows low in

social support were more susceptible to poor health. Berkman (1977) in a ten year study of mortality in California, found the highest rate of death from all causes occurred among people with the fewest social contacts. Nursing home studies (Dunlop, 1976; Cohen, 1977; Barney, 1973) reported that a lack of a viable family support system, together with chronic illness, were the two most common factors leading to nursing home placement.

Several programs utilizing older adults in supportive counseling with their peers have demonstrated the effectiveness of this approach (Waters, Fink and White, 1976; Bolton and Dignum-Scott, 1979; Becker and Zarit, 1978; Salmon, H., 1979). The Oakland Model (Waters et al., 1976), which used peer counselors as facilitators in personal growth groups, clearly demonstrated the benefits to the peer counselors as well as to the group participants. At the Nebraska Center for Aging, trained peer counselors served as role models for their peers and facilitated assertiveness and problem-solving in their clients. The success of these programs tends to confirm Rosow's (1974) theories on the value of peer groups for the elderly, "not bound by youthful norms." Peer counselors function as "qualified role models," in Rosow's terms, readily accessible to their peers, presenting themselves as "average" older people, not exceptions. These programs provided group support and, perhaps most important, expanded opportunities for specific leadership roles. Indeed, Babic (1972) and others have stressed the need for older volunteers to have a choice of roles with the opportunity to change and grow as skill and confidence develop.

IMPETUS FOR THE PEER SUPPORT SYSTEM

When the Turner Geriatric Clinic opened, 400 people came to an Open House/Health Fair and patients began making appointments. The first group of patients were predominantly sixty to seventy years of age, in generally good health, of middle income, and higher than average educational background. They came to the Clinic for a variety of reasons: an interest in preventive care; the need for a primary-care physician; at the urging of their adult children, who were concerned about the quality of medical care they were receiving; or the desire for a second opinion.

We were struck by the need these people had for information and attention. Frequently people would tell us of their frustration with doctors who only had a few minutes to give to each patient, "rushing me in and out," or the family doctor who said, "What can you expect? You're just getting older. Nothing can be done about it." Despite their relatively advantaged situation with regard to their current health, many of these people had generalized worries about the future, and a set of specific concerns: for example, treatment of chronic conditions, exercise and diet, the effects of new drugs, addiction to drugs. In a sense, their worries were the product of too much rather than too little information; magazines, newspapers, and television are a source of varied information about health, but do not provide systematic, relevant information for the elderly.

As we thought over these problems and talked with patients, it became apparent that most of their concerns were shared by many, rather than being individual complaints. For example, worries about cataract operations, memory lapses, hearing loss, stiffening joints, and general uncertainties about how all these might threaten independence were held by the majority of our elderly patients. While the Ann Arbor community offered a variety of services to senior citizens, most were recreational in nature, with occasional talks about health on a general level. Health screenings and blood pressure clinics were held regularly but were limited in their ability to address many of the individual's concerns. Our patients looked to The University of Michigan for information of a higher quality.

The social worker at the Clinic wished to respond to these needs with a program, but was concerned about the way in which previous programs she had been involved in were organized. Often, when the opinions of elderly clients were solicited about their needs, it was after a program was established. It seemed clear to her that input was needed from the elderly before beginning a program and that once it was established, an effective means of involving them in the program was essential.

FORMATION OF THE PROGRAM

Serving in the capacity of Clinic social worker, the co-author of this manual, who later became Director of the Peer Support System, learned of a program at Oakland University (Rochester, Michigan) which was using peer counselors to focus on personal growth and suggested it could be successfully adapted to a health education and maintenance framework.

Recruitment of Peer Counselors

The first steps were quite informal. To identify a nucleus of older adults with leadership potential who might serve as peer counselors, the social worker and a graduate student in psychiatric nursing (who later became the program coordinator of the project and co-author of this manual) spoke to groups from churches and elsewhere who visited the Clinic. We screened likely patients and asked colleagues and social agency staff to suggest candidates. Eighteen prospective peer counselors were then contacted by telephone and letter and invited to a meeting to discuss ideas for a new health education and maintenance program.

Nearly all who were invited came to the meeting and a few brought friends. We asked each attendee to describe his or her background. Their accomplishments impressed and occasionally intimidated each other but the high caliber of the group gave the participants a feeling of being involved in something exciting.

We explained that we were seeking a way to bring the knowledge available at The University of Michigan directly to the older consumer and we wanted older people to take the responsibility for deciding how and what should be presented. We stressed the fact that we had no ready-made program and would be working together with peer counselor volunteers to come up with a format. We asked them to think about these ideas and said we would be in touch later to see who might wish to be peer counselors, although at that time we had only the loosest idea of what peer counselors might do. Twelve members of this group ultimately became peer counselors.

Format Development

The next meeting was held two weeks later to discuss the format of the program. The staff suggested a workshop--a presentation by a speaker followed by a discussion. We brainstormed what to talk about and how to structure the workshop. One of the peer counselors was impressed by a column in the local newspaper written by a person from the Consumer Action Center; others noted that it would be good to use a broad definition of health and that consumer oriented issues could motivate people to become more informed. So the first topic, Consumer Action, was developed with everyone offering opinions and ideas on ways to present the most important points. We all thought we should aim for a large attendance to help emphasize the importance of the workshop.

The first peer counselor meeting and the one following it were taken up with plans for the first workshop scheduled in January, just about one and a half months after the initial gathering. The peer counselor meetings were remarkable for the warm, friendly tone set and for the ability of the peer counselors to modify the co-leaders' agendas and yet take care of the business at hand.

Staff Interaction with Peer Counselors

It may be uncomfortable for the professional to work in such a loose style, where issues and decisions are set by a nonprofessional group. However, an agenda helps refocus if the discussion roams off target. The primary roles of the staff co-leaders are: (1) to draw out ideas, (2) to create an atmosphere in which ideas are shared and people are acknowledged for their contributions, and (3) to supply helpful suggestions.

Interestingly, we noticed the devaluating effect that retirement can have on even a highly skilled person. It was necessary to repeatedly assure the counselors that it was their expertise we wanted, that the staff were not to be considered the voices of authority or superior knowledge. They knew about growing older in a way we could not. They also had professional skills of their own, whether they had been housewives or nurses, and we needed to draw on their experience. As the meetings progressed, the co-leaders repeatedly benefited from the energies of twelve elderly creative individuals.

At these meetings the role of the peer counselor began to be defined. We worked out the date, time, and schedule for the workshop and each peer counselor was assigned a specific task. By the week of the first workshop several key decisions had been made: (1) the first hour would be

the speaker's, including at least a half-hour of questions, and then a break for coffee and tea; (2) senior citizens who had been trained in Detroit as consumer advocates would speak briefly after the break about the work they were doing. We then would divide into two discussion groups, each facilitated by two peer counselors. The peer counselors felt that the combination of a large and small group would put the participants at ease and those who felt uncomfortable bringing up personal questions in a large group might feel safer doing so in a small group. We also felt this would give the peer counselors an opportunity to identify people they might want to approach later for more individual attention.

Other preparatory steps were taken: (1) a list was compiled for participants to select topics of interest for future workshops; (2) a short evaluation was composed for participants to fill out at the conclusion of the workshop; (3) peer counselors prepared and distributed a flyer and put publicity releases in the local newspapers and on radio stations; (4) arrangements were made for cooperation with the Washtenaw County Council on Aging; (5) small group discussions were role-played so that peer counselors could practice leading a group. Using a set of questions about consumer issues, the peer counselor group divided in half, and two peer counselors were leaders. We gave the group leaders suggestions and feedback on the sessions.

First Workshop and Follow-Up

Although it snowed the day of the workshop, over 60 people came--well beyond our expectations. The speaker was excellent, the format worked well, and the audience had so many questions that the peer counselors did not have to use their prepared questions. The eagerness of people to participate and contribute was notable. It became one of the important features of this program. Members of the audience shared information on funerals, on bad insurance companies, on problems in returning purchases to stores, and on what several of them saw as discrimination against the elderly consumer. People left with the feeling of having learned something new and of having contributed as well.

In a brief meeting after the workshop, peer counselors were able to congratulate each other on the successful start and also enumerate some problems: poor seating arrangements, inattention to visual and hearing impairments, an awkwardly placed refreshment table, confusing instructions on dividing into small groups, plus the embarrassing fact that many in the audience found parking tickets on their cars when they emerged a few minutes later than expected. But the mood was exuberant--one elated peer counselor said, "I really didn't think anyone would show up."

Over the next six months and six workshops, we followed basically the same model. Workshop topics were developed one by one. The format was reinvented at every occasion, with changes dictated by the nature of the topic, number and characteristics of the speakers, experience at previous workshops, and new ideas from the counselors. Attention to details was a significant element of the program. We wanted our audience to get what they needed, to be given an opportunity to contribute, and to leave with a sense of enjoyment.

In some sense the description above is contrary to program planning theory. We started with only a dim notion of goals and set new objectives as the program developed, depending on the interests and skills of peer counselors, staff, and students. It may be noted, however, that Hilda Ross, in her description of the neighborhood family program, reports much the same process (Glasscote, 1977).

PROGRAM OBJECTIVES AND METHODS

With funding from the Administration on Aging, the Peer Support System developed in accord with the following objectives and methods:

Objectives	Methods
1. To provide up-to-date information on issues affecting the health and well-being of older people.	a. Speakers at monthly workshops. b. Handouts and brochures at workshops. c. Once a month peer counselor in-service training meetings. d. Development of informational materials, i.e. Housing Booklet.
2. To involve older people in the planning and implementation of the program.	a. Peer counselor group. b. Short evaluations at each workshop. c. Long checklist of topics distributed to workshop participants at regular intervals. d. Telephone evaluations at Turner Clinic and Saline site.
3. To reach a large number of people with differing needs.	a. Expansion to three new sites. b. Wide publicity in senior newsletters, church bulletins, newspapers, and radio. c. Peer counselor talks in senior housing, churches, and senior centers.

		d. Peer counselor home visits. e. Wide range of small groups and workshop follow-up sessions.
4.	To provide varying levels of involvement, various levels of entry.	a. Encouragement of referrals from in-patient and out-patient social workers in medical and psychiatric divisions. Provision of program information to hospital discharge planners and social agency personnel. A range of services from large monthly workshops through one-to-one counseling at home. b. Small groups directed to specific targets--e.g., those with severe memory loss, hearing and visual impairment, exercise. c. Clinic staff informed of programs. Provision for peer counselor, student, and/or project staff involvement with clients having psychosocial problems, i.e., loneliness, isolation, lack of mobility.
5.	To provide a link with community resources.	a. The best speakers on each topic. b. Time for questions and individual discussions with speakers. c. Availability of literature on what agencies in the area offer services pertinent to the topic discussed. d. Peer counselors informed of resources and changes in personnel and locations to pass on to workshop participants, clients, and group members. e. Special forums on timely issues--e.g., transportation workshop when Senior Dial-A-Ride schedule changes were made; Elderhostel information meeting where people who had been to Elderhostel spoke, and registration information was distributed.

SITES

Although we found that the program was effective in a largely middle class population interested in maintaining good health, we weren't confident that it would work with a less healthy, less affluent group. We also wondered what effect the setting--a new and attractive geriatric health clinic affiliated with a major university--had on the success of the project. In October 1978, under an Administration on Aging demonstration grant, we went into three very different locations to test the basic model. In each site we spent over a month getting to know the individual community. We had a clearer idea of what we hoped to accomplish than we had earlier; essentially we wanted to work with peer counselors to set up a program appropriate to each site, rather than to bring a pre-set plan. Certainly such topics as arthritis and visual impairment were important at all the sites, but the group process of working with peer counselors to establish the program was itself the first goal. We planned that six monthly workshops would be developed at each site with monthly workshops continuing at Turner.

1. Turner Geriatric Clinic is in Ann Arbor, Michigan, a town of 100,000 in which The University of Michigan exerts a strong influence. The Clinic is a new two-story, barrier-free building. It is five minutes from the main University Hospital complex. Directly behind the Clinic is a city park and the Huron River, visible from many of the rooms. New furniture helps to create an impression that is different from the often "make-do" sites of senior citizen meetings. We also enjoy several rooms, using one large meeting room and several smaller rooms for discussion groups of 10 to 15 people, one room for hanging coats, and a long hallway for refreshments and socializing during the break.

The people who come to the Turner workshops, like the Turner peer counselors, are articulate and mostly white, many with college degrees. They may not be typical of this generation of older people, but they are a good forecast of older populations in the future who will have a much higher educational background. They are a critical group, can easily spot condescension. They are respectful of experts but not afraid to question the source of the expertise. They are an appreciative, responsive audience with a willingness to share experiences that enriches the discussion period.

Transportation to Clinic workshops is usually arranged by the participants. Some come on Dial-A-Ride, the local senior transportation system. Some are picked up by Clinic staff or peer counselors.

2. Chelsea Methodist Retirement Home is a 200 bed facility with a range of living situations, including independent apartments on the grounds of the home, a retirement home section, and a nursing section. Residents must enter the retirement home first before they are admitted into the nursing home; both are in the same building. Nursing home residents are in their late 80s and 90s, with a few centenarians. Hearing and visual impairment are severe. Residents, particularly on the third floor, suffer from mental impairment and are often confused.

Because of the frailty of this group we decided to use Turner peer counselors who were already familiar with our program and recruit local peer counselors later. After five months we recruited and trained six peer counselors from the Chelsea community to carry on the work of the Turner peer counselors. Working very closely with the staff, particularly the director of nursing and the activities director, we focused our efforts on the nursing home. The peer counselors each visited a number of residents weekly to become acquainted with them and the kind of program they needed. Difficulties included: (1) finding a suitable room in which to meet, (2) physically transporting people on one very slow elevator, and (3) finding ways to surmount the hearing and vision impairments. Attendance at each session ranged from 15 to 30 people, with a larger number, including retirement home residents, joining us at the end of the project for a Japanese tea.

3. Saline Community Hospital is our rural site. Saline is a town of 7,000 surrounded by farm land. Saline Community Hospital is a fairly new facility built with donations from community residents. The hospital facility is adjacent to Saline Evangelical Nursing Home, separately financed and administered. The workshops here have drawn peer counselors and participants from Saline, nearby Manchester, and the outskirts of both towns. Participants, largely of farming background, have strong ties to the community with a tradition of "taking care of our own." However, fewer community services are available for senior citizens than in Ann Arbor.

Two residents of the small apartments in the nursing home were peer counselors. Through them nursing home residents were encouraged to attend the workshops, although not many of them did because the time of the workshop conflicted with their meal schedule. We worked closely with the community services nurse at the hospital who was very knowledgeable about the community and eager to have us bring our

program there. Later, workers from the community mental health office remarked on the unusual cooperation that developed between peer counselors from Saline and Manchester, two self-contained towns, which helped to draw workshop participants from both communities.

Transportation was usually arranged by the individual, although peer counselors set up car pools from Manchester. Attendance ranged from 50 to 107 persons, and the opportunity to have an excellent and inexpensive lunch in the hospital cafeteria after the workshop was an effective lure.

4. Ypsilanti Area Nutrition Sites (the Hawkins Street site, meeting in a church basement in the city of Ypsilanti, and the Willow Run site, just outside the city, in Ypsilanti township) were selected as the low-income locations. The Hawkins Street site is predominantly black, the Willow Run site racially mixed. Both sites have a majority of low-income senior citizens, many with only an elementary school education. Ypsilanti, though neighboring Ann Arbor, is quite a different community (the average family income according to the 1970 census if $4,803 as compared to Ann Arbor's $8,037). Many of the participants at the sites came to this area from the rural South to work in the automobile factories or the Willow Run Bomber Plant during World War II. Of the nine peer counselors, five were originally from the South.

Our original idea was to meet alternately at each site, but the peer counselors felt the Hawkins Street site was too limiting and preferred the Willow Run site, which had moved shortly before our program began to a cheerful one-room cinder block building. An adjacent room in the next building, belonging to Adult Education, provided an excellent meeting room, complete with stage and projector screen. Most of the people came to the site on buses provided by the Senior Nutrition Program operated by the Washtenaw County Community Services Agency. Attendance ranged from 50 to 96, and the workshops were held just as lunch ended.

Project Duration

We were well aware, from our experience at Turner, that six months at each site would just be enough time to get the peer counselors off to a start. So from the beginning we tried to work toward continuing each project. The Turner Clinic program continues with the support of local grants and Clinic staff. This includes funds from the Area Agency on Aging, The Ann Arbor Foundation, and the Friends of the University of Michigan. Individuals have made contributions to the program through a gift fund. The activities director, who worked closely with Peer Support System staff, is

directing the effort at Chelsea Community Hospital with the help of local people and other local resources. Fortunately, the Ypsilanti project continues under the auspices of The University of Michigan's Institute of Gerontology, which has a grant from the Community Services Agency to do a similar program of health advocacy. Ypsilanti peer counselors help train people in other areas to do the kind of work they have been doing in the nutrition site. Saline Community Hospital continues to sponsor their group, assisted by a worker from Community Mental Health, who has attended many of the peer counselor meetings from the start of the project. The fact that most of the peer counselors are not only eager to continue but want to add new members and start new programs, repeating the process that occurred at Turner Clinic, convinces us that this is a flexible model with growth potential and adaptability to very different settings.

STAFF AND FINANCING

During the first year, the staff of the Peer Support System consisted of the Turner Clinic social worker, working half-time on the project and half-time with patients in the Clinic; the program coordinator working half-time, and a half-time assistant. During the second year, the program coordinator increased her work to full-time. Generally two staff people worked with peer counselors at each site. The program assistant's duties ranged from clerical and secretarial work to organizing and running small groups, assisting at the sites, and coordinating the evaluation interviews.

In addition, 17 students worked at various times as group leaders, organizers, and administrative assistants. The grant provided funds for travel expenses and for stipends to acknowledge the value of the work of the peer counselors. Of the 48 peer counselors, 12 received a stipend for the maximum of $51.00 per month. The other peer counselors were registered in the Retired Senior Volunteer Program (R.S.V.P.) and received reimbursement for transportation. Consultants to the program included the Turner Clinic physician, psychiatrist, nurse clinician and dietician, the director of social work services at The University Hospital, and other University and Hospital personnel.

At the beginning of the program, the activites were seen as a part of the Clinic social worker's responsibilities. With AoA funding, the Hospital continued to support the social work position. For the period from 9/29/78 to 9/29/79 the amount of AoA support was $30,000; the sum for 9/29/79 to 9/28/80 was $43,406.

PEER COUNSELING

Peer Counselor Backgrounds

The 48 original peer counselors represented a wide range of backgrounds and personalities. Twelve were male, 36 female; ages ranged from 52 to 83 (the 52 year old faced early retirement due to disability; the next youngest person was 60) with an average age of 70; 2 were single, 21 married, 23 widowed, and 2 divorced. Nine completed elementary school, 4 had some high school, 13 had some college, and 13 had a college degree. Nineteen were trained at the Turner site, 14 in Saline, 6 in Chelsea, and 9 in Ypsilanti.

Past occupations of the peer counselors included teacher, nurse, secretary, librarian, businessman, clothes presser, domestic worker, minister, plumber, farmer, mechanic, custodian, and housewife. At the beginning of the program, most were retired although eight were working part-time. Sixteen had participated in some form of group or individual counseling before entering the program.

When asked if their favorite people were: (1) about your own age; (2) much younger; (3) much older, and (4) 65 years and older, the majority responded to (1) "their own age." Of the friends and relatives they see regularly, a large number of friends fall in the over 60 group but contact with all ages is evident, with a great number of contacts in the 25 to 60 age range.

Peer Counselor Recruitment

Recruitment varied at each site but, generally, recommendations were given by professionals (nutrition site managers, nursing home staff, community agencies). Some heard about it through the newspaper, and others were recruited when Turner peer counselors visited senior centers and nutrition sites to talk about the program. In the rural community, individual invitations, usually through a known and trusted person, were essential to encourage people to attend a first meeting. The potential peer counselor was interviewed by project staff to discuss program opportunities. Important considerations were the emotional state of

the person, i.e., that this was not a period of stressful life change, and time was available to make a commitment of at least ten hours a month. Equally essential were an interest in providing a service and the ability to listen (see Guidelines for Recruiting Peer Counselors, p. 61).

One of the reasons some of the peer counselors were attracted to our program was because it promised more stimulating and rewarding activities than certain previous volunteer experiences. For example, a former high school principal, interested in community mental health, had once been given a cart to wheel around in a psychiatric hospital. In the Peer Support System, however, his ideas were important in planning workshops, he had contact with interesting people as he sought speakers and explored topics, and he worked with staff and another peer counselor in developing an innovative program for people with "normal" memory loss. He saw an 86-year-old depressed man weekly for a period of over a year who recently wrote, "He was a lifesaver at times when I was down in the dumps."

Another woman, a retired teacher whose specialty had been retarded children, worked with a gerontology student and a nursing student to develop a weekly program for Clinic patients living in the community who had mental impairment. Her determination to treat these people as adults, despite their confusion and memory lapses, led to experimentation with art, exercise, memory training, and discussion groups with visible benefits for the participants and their families.

Three peer counselors at three different sites had artistic talent and were recruited to do monthly flyers. One man, a resident of Saline Nursing Home, created a distinctive touch with cartoons illustrating such things as an arthritic patient and Popeye exercising his muscles. A woman, who had always wanted to be a newspaper reporter, took pride in the press releases she sent out weekly and battled with the newspapers when they omitted a notice.

Peer Counselor Training

Training varied with the site, but the overall goals were: (1) to teach peer counselors how to conduct workshops that would best meet the needs of people at their site, and (2) to acquaint the peer counselors with each other, thereby establishing a sense of identity as a peer counselor group. The first two training sessions developed at Turner established a norm that each person's ideas were valued and that everyone had something unique to contribute. Although some basic counseling skills and group techniques were taught, an effort was made to encourage the peer counselors to discover

and develop their own talents and resources (see Peer Counselor Training Sessions, p. 65).

At the three sites, Turner peer counselors took part in the training, serving as role models. At each site, the unique requirements of that site were foremost. In the Nursing Home, classes were conducted jointly by project and nursing staffs, and special concerns of nursing home residents were covered along with details about how to continue the workshop program. In the rural site and the nutrition site, modifications were made through discussions in peer counselor training sessions on the specific needs, problems and values held by people at their sites.

The usual orientation sessions lasted six weeks and were followed by ongoing meetings twice a month in which peer counselors planned workshops, developed new ideas and heard speakers talk on community resources. Babic (1972) has written that ongoing, informal continuing education has the best results for maintaining the interest and retention of older volunteers. Moreover, the peer counselors found the support received at these meetings was an important factor in their decision to continue with the project at all sites after the "Turner" people left.

Peer Counselor Responsibilities

1. Workshops

The primary responsibility for peer counselors was to organize and develop ideas for workshops. Peer counselors worked out workshop formats and made sure that they proceeded smoothly. At the Ypsilanti site, for example, they introduced site managers who in turn introduced speakers. They reserved a front row for people with hearing problems and welcomed people.

The peer counselors' dress at each workshop set a festive tone that the other seniors responded to. One peer counselor wore a long dress and a corsage at the first workshop. Another peer counselor, who moderated at the question period each time at the Ypsilanti site, always announced at the end: "We are the peer counselors. This is your program. You let us know what you want to have here and we'll arrange it for you. If you have any problems or questions, let us know."

To select topics for workshops the peer counselors began by discussing subjects and ideas which interested them. From these ideas a checklist was compiled and given to participants at the first workshop and at regular intervals thereafter (see Checklist for Workshop Participants, p. 85). Topics with the most interest were selected. An important

part of the selection process was the development of workshop ideas. Peer counselors combined related topics, on occasion adding an entirely different slant. The entire group brainstormed what interested them about a particular subject, what they did not know and what they thought would be important to others. When the topic was controversial, as in the case of vitamins, all sides were presented. Suggestions for speakers were generated by the group, but a committee of peer counselors volunteered for each workshop and met with prospective speakers to discuss what they wanted him/her to talk about. Although this may sound very basic, it was the most essential part of workshop development. It helped the professional "experts" avoid the temptation of deciding what was best for clients. A letter was sent to the speakers to confirm the date and to review the topics to be discussed. Although this method was not foolproof, combined with the insistence on equal time for questions, it increased the likelihood of receiving relevant information.

Another peer counselor responsibility involved collecting hand-outs for each workshop from agencies, government offices, occasionally xeroxed articles from books and magazines. For a nutrition workshop, one display table had samples of tofu (bean curd), another had sprouts with growing directions, and packages of free seeds were available along with the usual pamphlet assortment.

The peer counselors facilitated group discussions by sharing their own experiences. In Saline a panel of peer counselors discussed how they coped with depression at the "Chasing the Blues" workshop. On another occasion, one peer counselor gave a talk and demonstration about the correct way to walk while another discussed techniques for fitting shoes. At each site the peer counselors welcomed participants with their warmth and friendliness.

At peer counselor meetings a broad range of concerns came up which peer counselors felt should be dealt with at workshops. One of the issues at the Ypsilanti site had to do with two new senior citizen housing complexes into which a number of the site members had recently moved. Conflicts between the elderly tenants and the younger handicapped tenants were causing a great deal of stress. As the project continues, the Institute of Gerontology staff and the peer counselors are planning a workshop which will address these problems.

2. Individual Counseling

Babic (1972) and Sainer (1972) have discussed the reluctance of older volunteers to take on a "person-to-person"

relationship until they become comfortable with the setting and understand their place in it. Since individual counseling was an outgrowth of the program, people could gradually assume that role. Some peer counselors were interested in it from the start and their willingness to take on individual clients prompted us to begin this service. A peer counselor who is legally blind helped organize the Low Vision group and workshop but was also interested in talking individually to low-visioned people and their families and did a great deal of counseling over the telephone as well. She has organized an Eye Information Center where she has been available to talk to people on a drop-in basis. She has visited inpatients who have had eye operations and also has visited residents in a nursing home (see Examples of Individual Counseling, p. 76).

Other peer counselors were never interested in taking on what they saw to be the heavy responsibilities of counseling another person. Some who started doing it found it upsetting or time consuming or "not for them." Despite the success of many widow-to-widow programs, for example, our experience indicates that a woman who has come to terms with her own widowhood can still be shaken and upset by helping another widow.

Peer counselors who were themselves coping with chronic illnesses were not always patient with others who were not doing as well. There is a particular tendency among those who pride themselves on managing well to be impatient with the "complainers". The professional has dealt with the frustration of working with a client and not seeing progress; for the peer counselor this was often hard to accept. For some people we felt it was best that they not do individual counseling--and, unfortunately, we were not always able to predict this before they started working with clients.

When a peer counselor was appropriately matched with a client and was given staff support and suggestions, the result was valuable for both people. One peer counselor, who came to the program wanting to do individual counseling, has grown considerably in confidence and skill. Her empathy with the people she sees has been great and she has been able to see now what she could not always recognize before--the positive effects of her intervention. Zarit et al. (1978) presented a good model for an individual counseling program and emphasized, as we do, the necessity of professional support and feedback.

3. Small Groups

Frequently workshops served to introduce new ideas and to stimulate interest in pursuing a subject in more depth.

As a result, the formation of many small groups grew out of workshop presentations. After the low-vision workshop, for example, several people were interested in more information and formed a support group. Two peer counselors with low vision (one legally blind) assisted with the organization by phoning prospective members and, most importantly, by using their experiences to plan the kinds of programs other people with the same problems would find helpful.

The idea for a Newcomers group came from the experiences of a peer counselor who moved to Ann Arbor as an older person and felt the lack of a program geared to the needs of people in her situation. A Saline peer counselor, who had a relative in a nursing home, started a Family Support group so that families could talk to each other about their concerns and learn ways to be supportive to their relative. The group was jointly led by the peer counselor, Peer Support staff, and the activities director of the nursing home (see Descriptions of Small Groups, p. 95).

Peer counselors took part in all the small groups. Their involvement ranged from generating ideas for various kinds of groups, to suggesting specific activites for the group, to co-leading. Decisions about content, approaches, and leadership of small groups were made jointly by peer counselors and staff, and discussion after each session was customary.

Usually sign-up sheets were circulated at workshops to see if people were interested in more information. Clinic clients and others were added to the list. When dates were set for the first meetings of small groups, letters were sent to potential members explaining the purpose of the groups. In many cases follow-up phone calls were necessary to encourage people to try out new groups or to assist in arranging transportation. Newspapers, church bulletins, and senior citizen newsletters printed announcements of groups.

Most small groups met weekly for six to eight weeks. The Low Vision Support and Writing Groups were exceptions, both having continued for over two years. The usual format consisted of two-hour sessions with a break after the first hour. Most groups took place in the daytime to accomodate transportation, except for the family groups which met in the evening.

Some participants found discussion easier with a small number of people. Many personal experiences were shared and new ways of handling problems were considered. Participants often commented on how helpful they found learning about other people's experiences with problems similar to their own.

Variety of Activities

One of the advantages of our program--and most successful volunteer programs--has been the variety of opportunities available for peer counselors. They have done any number of tasks connected with workshops; they have participated in small groups as co-leaders and participants; they have proposed an idea and have followed it through, for example, setting up a file of people who would like to share hobbies or interests with other people.

However, the stimulation and enthusiasm of the peer counselor meetings sometimes has had a boomerang effect. Some counselors became too involved and, before they realized it, spent more time than they had expected on peer counselor activities. Being responsible, highly reliable people, they hesitated to tell the staff that they were overly committed. We learned the necessity of keeping in touch with each person to make sure this did not happen.

At peer counselor meetings, we periodically asked people to write down what they were doing, what they would like to be doing and how they felt about their time commitments. This was important because it was easy to say, "Let's do this," have the peer counselor eagerly agree, and later find out that she or he was not able to say "no". Assertiveness training exercises might be helpful in these situations. We found that giving people time at peer counselor meetings to discuss their work and problems connected with it helped solve these difficulties.

Advocates

Although few peer counselors would have called themselves advocates, the fact that they were better informed about services and resources than the average person and had a number of channels through which to spread this information placed them in this role. For example, one of our peer counselors effectively convinced people that they have a right to ask questions and receive answers from opthamologists and others who work with the visually impaired. Peer counselors have written letters to editors and taken part in community planning meetings and advisory groups. Perhaps the most important aspect is that they are models, by their behavior and attitudes, of older adults who are active participants in their community and able to take responsibility for issues affecting their interests and the needs of those less able. Irving Rosow (1974) wrote of the need for older people to find positive role models among themselves so that they do not have to try to identify with younger people in order to maintain a respected role in

society. One peer counselor recalled with pleasure the remarks of a visitor in her twenties as she left a peer counselor meeting: "I just can't wait to get old."

WORKSHOPS

For the grant period, 10/78 through 9/80, 19 workshops were held at Turner, 6 each at Saline and Ypsilanti and 12 in the Chelsea Methodist Retirement and Nursing Home. Total attendance was 1,200 people with 2,509 participant contacts. The workshop format varied in each site. However, we followed certain basic procedures.

Speakers

An expert does not always communicate well with a lay person. Hence, we tried to choose not only the most qualified person in a given field, but also one who could talk effectively with people. Speakers met with peer counselors and staff prior to the workshop to ensure that they would address the concerns of the peer counselors during the workshop.

Our speakers, who were not paid, were associated with the University, local agencies, the police and fire departments, the public health department, the Red Cross, and other agencies where good information was available. Often, older people were the speakers or panelists or responded to the main speakers. At Turner and Ypsilanti, for example, peer counselors were the speakers for a workshop concerning growing old. An entirely different point of view was added to an Arthritis workshop by a woman who demonstrated walking canes she had devised and explained how and when she used each: a ski pole for icy weather, a large, colorful cane to alert children, and a cane with a small folding chair for museums.

Two points were considered essential: (1) although time varied from site to site, speakers were asked to limit their talk to 20 minutes and to allow an equal amount of time for questions, and (2) whenever appropriate, we invited more than one speaker to a workshop. Our intention was to present differing opinions on an issue. Also, in the case of a chronic illness, for example arthritis, the views of a physician, a nurse, and an occupational therapist were sought to present a complete picture of the problems. A

very successful workshop on nutrition had a panel of three nutrition experts who were not always in agreement about the issues discussed.

Peer counselors suggested speakers that we would not have thought of: an emergency room nurse to discuss how to get the best service there; a waitress to talk about how she trains her memory to get orders right; an exercise specialist to teach relaxation exercises in a workshop on sleeping problems. In addition, the peer counselors had a remarkable range of talents--one counselor, a retired shoe store owner, added immeasurably to the workshop on feet by explaining how to make sure shoes fit.

It was our experience that the most distinguished and busy people were pleased to speak at our workshops and, interestingly, to prepare themselves, several had to explore for the first time the special needs of the elderly (see Sample Pre-Workshop Letter to Speaker, page 87). Feedback from the speakers indicated that they felt the audience of older adults was responsive, appreciative and indeed, stimulating.

Topics

Brief written evaluations by audiences at each workshop provided space for people to list their suggestions for future workshop topics. Periodically a checklist of topics, composed by peer counselors, was distributed for participants to select subjects of interest (see Checklist, p. 85). Although we had a special interest in health issues, there were no subjects rejected unless we felt there were other groups in the community presenting something similar.

Finding the right title for workshop topics required considerable thought and prompted lively discussions in all of the peer counselor groups. "Winterizing Aching Bones and Joints," for example, was about ways to prevent falls on ice and snow and included exercises to keep muscles and joints in good condition. Because some topics, such as depression, were more personal, even threatening to some, the peer counselors decided that "Shaking the Blues," printed on a blue flyer, would make the subject more acceptable. And, in fact, 45 people attended.

Comparability of Sites

At all sites, peer counselors and participants enjoyed having physicians speak and especially appreciated the opportunity to talk to them during the break. Slides or films

were effective if they were not too long and were well produced.

Handouts had varied receptions. Turner participants cleared the table of handouts, no matter how many we had. They were almost as popular at Saline, but in Ypsilanti, where quite a few participants had difficulty reading, they were usually left behind. At the nursing home they helped people remember the workshop and important points of discussion.

Length of time was an important variable in all sites. The nursing home workshops never lasted more than an hour, and less time than that was preferable. Turner workshops went for two and a half hours with a break included; Ypsilanti an hour and a half (just in time for people to catch their buses home) and Saline, two hours. Staff must be alert to decreased attention spans and the negative effects of sitting too long.

At all sites, the question period was valuable. Although people complained that others sometimes talked too much, it was very rare for someone to say she or he did not get a specific question answered. Face-to-face contact with an "expert" drew people. One woman said after listening to a well known neurologist talk about strokes, "I never spent this long with a doctor in the same room before."

The kind of speakers available varied with the community, but we found that it was better to get a local person to speak at each site to inform people of what was available in their area. All communities have people who are interesting speakers--physicians, real estate agents, physical education teachers, lawyers. The topic is the important starting point; then the search for the speaker should begin.

Variation of Format

At Turner several rooms were available at the same time. This allowed considerable flexibility in planning workshop formats. Most often the first hour consisted of a main speaker or panel of speakers whose presentations took 20-30 minutes followed by questions and answers. At the end of the first hour a 15-minute coffee break ensued. The second hour frequently was designed to provide smaller group presentations and discussions. Sometimes each small group spent an hour discussing a topic, for example, how to handle depression. In other cases a speaker talked to one group for a half hour and then with another group for the following half hour. Occasionally, the groups exchanged rooms if the presentations could not be easily moved.

The Saline site offered lunch and for this reason the program was planned to end at lunchtime. People traveled as much as 25 miles to the workshop so this was an advantage. The hospital cafeteria made a special lunch and a peer counselor collected money for meal tickets before the workshop. Because lunch followed, the coffee break was omitted. Usually the first part of the workshop consisted of a speaker who allowed time for 25 minutes of questions and answers. A break of 10 minutes gave people a chance to get up and move around. The second hour was devoted to a panel discussion or a presentation with some movement or group participation, because space did not permit the use of more than one room.

The format was greatly modified at the nursing home site. Although a checklist was used to decide what topics would be presented, it was necessary for the peer counselors to talk individually with each resident. Specially made invitations were given to each and, in addition to adding a personal touch, they helped people remember date and time. The workshop took place for 45-60 minutes and only one topic was presented.

The most effective presentations in the nursing home included several modes of communication, and those illustrated by pictures, slides, or objects were more easily remembered. The residents were involved through group activities, passing around objects, and discussions which stimulated questions and comments.

For nursing home workshops hearing was a consistent problem even with good sound equipment. Smaller groups were tried with some success. The most effective speakers were those who knew how to speak to the residents without being condescending and without being disturbed by the frequent lack of responses. Speakers must be well prepared for the multiple sensory changes of the audience which affect their ability to give back non-verbal cues of understanding and interest (see Suggestions for Speakers, p. 86).

A meeting place outside of the residence halls gave an added feature of going out. Because it took quite a while to bring people in walkers and wheelchairs, an activity for those arriving first was very helpful. For the vision workshop we passed around visual aides from the Library for the Blind. At other times group exercise or singing, suggested by several residents, was led by a peer counselor. On one occasion, questions of interest were written down for the speaker in advance of the program, minimizing the wait for those arriving early. Tea at the end provided a closing social time.

NETWORK BUILDING

As the basic peer counselor/workshop model developed, it grew into a multi-level program that could handle people at different stages in life and with differing health needs. The three main avenues of development included: individual counseling, the organization of small support groups, and a growing referral and information service on health issues.

Requests for peer counselors to work individually first came from clinic staff and then from relatives and other agencies. In some cases a client was more accepting of a visit from a peer counselor than from a professional. In others, peer counselors supplemented professional services.

Frequently, these clients had many needs: the largest group were lonely and desired home visits, limited vision and health problems (including proper use of drugs) concerned many, and depression and memory changes were frequent. The peer counselors usually visited their clients at home, and their approaches were often original. A peer counselor worked with a woman with a severe vision problem who had a husband who was hard of hearing. During her visits, she made phone calls for the couple and introduced the woman to Talking Books. She was successful in assisting them in accomodating to the other's handicap and could directly help them when that was not possible.

Small support groups grew out of workshop presentations. For example, a group for people with "normal" memory loss developed after the workshop on that topic. Others included the low vision support group, the hearing loss group, and the arthritis support group.

The workshops not only provided the impetus for pursuing subjects in more depth but also supplied necessary resource people and material. As peer counselors and staff became more knowledgeable about these resources, the program was utilized by agencies and families. Counselors and staff consulted their growing files of literature and gave people up-to-date referrals. In the common yet confusing areas of eye surgery, hearing problems, and mental confusion this service became quite valuable. A booklet was written outlining housing options for seniors in the area complete

with costs and descriptions. Compiled by peer counselors and students, it has been updated, and nearly 250 copies have been distributed by Turner Clinic. Other agencies including Community Mental Health, Child and Family Services, and the Council on Aging have reproduced and distributed it to their clients. Literature on the seven week course has been assembled for distribution.

EVALUATION INSTRUMENTS

Measuring the effectiveness of this kind of program might be done by sophisticated, quantitative testing procedures which evaluate morale, well being, and the ability to maintain independent living among program participants. However, we chose a more qualitative way to evaluate that focused on two questions: (1) Are the workshops beneficial to the people attending? and (2) What is the effect of the program on the peer counselors?

Participants' Short Evaluation Forms

Short, simple questionnaires were distributed to all workshop participants at each site and collected following each workshop. Participants gave their opinions about the general success or failure of speakers, organization, information, and atmosphere, filled in suggestions for future workshops, and noted interest in attending more sessions on a given topic.

Variations on administering these occurred at the Chelsea Nursing Home and the Ypsilanti sites. At the nursing home, participants were very frail, physically and mentally. Because residents needed to rest after workshops, peer counselors returned the next day with evaluations. The peer counselors asked questions and wrote down answers for the residents. However, these participants were often unable to remember details or even that they had been to a workshop. Peer counselors became adept at soliciting opinions and evoking memories by bringing up certain details. (In the exercise workshop, hand cream was passed around and residents were asked to gently massage each other's hands. "Do you remember that nice smelling hand cream?" a peer counselor asked a resident, who then recalled attending the workshop.) Even if the residents could not remember details, they were usually able to give suggestions for future programs. Peer counselors noted an increasing familiarity with the program as they returned each month for the evaluations. In Ypsilanti, questionnaires were also administered by peer counselors because some participants had difficulty reading and writing. These often reflected the bias of the peer

counselors: the peer counselor who wanted a workshop on Problems of Aging found that all the people she talked with also wanted to hear about aging.

The importance of these short evaluations was that they gave us a continuing check on the relevance of each workshop to the audience. They assisted in planning further programs and they provided the impetus to expand the program with small groups.

Telephone Interviews of Selected Workshop Participants

At Turner Clinic and the Saline Hospital site, more detailed evaluations were administered by volunteers or peer counselors by telephone one week after the workshops. Approximately one-third to one-half of the participants at each workshop were selected on a random basis for telephone calls. New participants were selected in preference to those who came often in order not to irritate people with frequent phone calls and also to solicit opinions from a heterogeneous group. This longer evaluation gave us demographic information on our participants and told us how they used the information presented to help them in their daily lives.

Peer Counselors' Evaluations

At Turner Clinic periodic six-month evaluations were distributed that asked peer counselors to evaluate their satisfaction with the peer counseling experience in terms of tasks achieved, time spent, and plans for the future. They were asked to list problems they had encountered in the preceding months of program activities.

At the end of the two year period an evaluation discussion with each group of peer counselors was recorded. Peer counselors were asked a variety of questions about their experiences with the program. This method of evaluation was consistent with our philosophy of group interaction as a way to promote individual as well as group expression and growth.

During the course of the grant period peer counselors at Turner were given questionnaires to measure their subjective perceptions of self-esteem, energy, and personal relationships. The amount of activity, contact with family and friends, and volunteer work were recorded. The Rotter Scale was administered to determine locus of control. These measurements, similar to those used in the Oakland Peer Counselor Program (Reiter, 1979), were made before peer counselor training and six months and two years later.

EVALUATION RESULTS

This section will present the results of the evaluation process described in the previous section. The results will be discussed in relation to the program objectives.

Objective 1: To provide up-to-date information on issues affecting the health and well-being of older people.

The monthly workshops and small groups provided information about the changes that occur with aging--physical, emotional, and mental. A compilation of the short workshop evaluations (Table 1), showed that a clear majority felt that the workshop had given them new and practical information. The overwhelmingly positive response, as noted in these evaluations at all four sites, corresponded with comments addressed to peer counselors and staff during the course of workshops.

Table 2, collected from the longer telephone interviews, illustrated how the information was used. These interviews, done within two weeks of the presentation, revealed that roughly one-third of the people interviewed practiced a technique learned at the workshop, changed their habits, or felt a reduction in anxiety as a result of the material presented. Over half reported that their questions had been answered and, significantly, over 70 percent said they planned to use the information in the future. Since a large number of the workshop attendees were people interested in preventive medicine and in maintaining their present health status (a frequent response during the interview was, "Well, that's not a problem now but I wanted to find out about it so I'd know what to do when it is a problem"), we considered this a highly favorable result.

The workshops that offered concrete suggestions on either a technique to be practiced (heart problems, security, stress and exercise) or new habits to be adopted (money management, security, and nutrition) received the highest positive response. A majority of participants interviewed found the information useful enough to share with someone else, an adult child, spouse, or most frequently, a friend (Table 3). When handouts were available,

TABLE 1

Participants' Short Evaluation Forms

Workshop	No. of evalu-tions	Workshop gave new info	Peer Coun-selors were helpful	Info was prac-tical	Enjoyed be-ing with older people
Housing	26	92%	58%	81%	73%
Younger Than Springtime	15	100%	100%	100%	87%
As Your Children Grow Older	24	79%	83%	87.5%	87.5%
Head to Toe	42	95%	71%	93%	76%
Arthritis	41	97.5%	85%	97.5%	83%
Winterizing Bones and Joints	18	100%	100%	100%	94%
Stress	28	86%	78.5%	93%	89%
Heart	43	95%	88%	98%	72%
Living Alone	15	93%	80%	93%	80%
Security	18	100%	83%	100%	88%
Money Management	32	94%	69%	91%	97%
Nutrition	21	100%	.90%	95%	90%

TABLE 2

Telephone Interviews: Ways Information was Used

Workshop	No. of evalu-tions	Practiced techniques	Relieved anxiety	Changed habit	Sought more info	Answered questions	Info will be used in future	Other
Arthritis	30	23%	20%	27%	7%	37%	43%	7%
Heart	14	29%	7%	29%	29%	51%	51%	7%
As Children Grow Older	16	19%	31%	25%	13%	37%	63%	0%
Nutrition	8	25%	13%	62%	62%	37%	75%	0%
Security	12	42%	42%	42%	33%	66%	100%	0%
Younger Than Springtime	23	22%	4%	4%	4%	10%	60%	0%
Stress	16	38%	38%	19%	13%	44%	56%	12%
Making It Alone	16	6%	13%	0%	33%	33%	56%	12%
Housing	27	11%	11%	0%	33%	33%	56%	0%
Winterizing Bones and Joints	9	44%	11%	22%	66%	44%	100%	0%
Money	10	0%	50%	33%	80%	70%	80%	0%
Depression	7	29%	29%	15%	43%	58%	58%	43%

TABLE 3

Telephone Interviews: Persons With Whom Information Was Shared

Workshop	No. of Evalu-tions	Did you share info? Yes	No	NA	With whom? Wife	Husband	Adult child	Friend	Other	NA
Arthritis	30	80%	20%	0%	0%	20%	7%	63%	7%	10%
Heart	14	50%	36%	14%	0%	14%	7%	29%	7%	
As Children Grow Older	16	63%	31%	6%	0%	19%	25%	31%	13%	
Nutrition	8	75%	25%	0%	0%	0%	13%	63%	13%	
Security	12	92%	8%	0%	0%	8%	16%	58%	8%	
Younger Than Springtime	23	74%	17%	9%	13%	13%	13%	36%	4%	
Stress	16	75%	19%	6%	13%	25%	6%	31%	0%	
Making It Alone	16	75%	13%	12%	0%	6%	6%	69%	13%	6%
Housing	27	63%	30%	7%	0%	4%	26%	48%	4%	
Winterizing Bones and Joints	9	89%	11%	0%	0%	0%	35%	56%	33%	
Money	10	70%	10%	20%	10%	20%	40%	60%	10%	
Depression	7	100%	0%	0%	0%	14%	28%	86%	0%	

a majority picked them up and remembered them when they were interviewed two weeks later (Table 4).

Evaluation data in this area came also from speakers and individuals. For example, a professor of nursing and speaker at the stress workshop reported that a number of the participants called her after the workshop to say her remarks had relieved their concerns, and they would continue practicing her stress management techniques. Vision and hearing workshops produced a high number of responses of this type, specifically in regard to information presented on cataracts, visual aids, and hearing aids.

Although learning new information, by itself, did not necessarily lead to behavioral change, in certain instances, as indicated above, it provided the necessary motivation and allayed worry. The memory workshop and the subsequent seven week memory group illustrated how information about normal changes in memory with aging and, particularly, the difference between normal changes and disease processes relieved anxiety. The nurse leading the sexuality discussion group received a call from one of the participants who said that as a result of the group, she and her husband were able to discuss their feelings about sex for the first time in their long years of marriage.

Objective 2: (a) To involve older people in the planning and implementation of the program; and (b) to evaluate benefits to peer counselors resulting from their involvement.

The checklist of topics and the two evaluation forms ensured input from older people in planning the program. The key role, however, was performed by the peer counselors in the four sites. Of those 48 who completed the training originally, 5 dropped out of the program (1 had too many other commitments, 1 accepted a part-time job, and 3 had failing health).

We observed that peer counselors became more assertive in their roles, gradually assumed more responsibility, and eventually took the initiative instead of deferring responsibility to a staff person. Their skills in planning programs, group leadership, and individual counseling also improved. In the short evaluation forms, the majority of participants noted that peer counselors were helpful and, in addition, the friendly atmosphere of the workshops was often attributed to the efforts of the peer counselors.

Our observations of individual growth were not verified by the three instruments we used to assess changes in behavior, attitudes, and locus of control. Attitudinal dimensions--overall feelings about self, relationships with family

TABLE 4

Telephone Interviews: Use of Handouts

Workshop	Attendance	Number of Evaluations	Did you take handouts? Yes	No	NA
Turner					
Housing	60	27	70%	30%	0%
Younger Than Springtime	30	23	25%	65%	10%
Arthritis	80	30	77%	23%	0%
Winterizing Bones and Joints	40	9	78%	11%	11%
Stress	60	16	81%	12%	7%
Heart	75	14	79%	0%	21%
Making It Alone	50	16	69%	25%	6%
Security	30	12	50%	50%	0%
Money	60	10	100%	0%	0%
Nutrition	60	8	75%	25%	0%
Depression	45	7	86%	14%	0%
Saline					
Feet	52	8	100%	0%	0%
Heart	80	22	95%	5%	0%
Arthritis	126	31	90%	10%	0%

and relationships outside of the family--remained the same with the two groups of Turner peer counselors tested. The first group was tested before training, six months later and two years later; the second group, before training and one year later. Physical energy decreased very slightly which was perhaps understandable as the group grew older. There was also little change on the Rotter score; peer counselors started out as being highly inner-directed and stayed at about the same level.

On behavioral dimensions, all peer counselors continued to do household chores on a regular basis and, except for two people, did volunteer work for another group besides Turner (frequently a church). All had weekly to monthly contact with family and weekly to daily contact with friends. Family contact tended to be regular but less frequent than with friends. With one exception, all had many friends and acquaintances. These dimensions remained unchanged throughout the course of the grant.

Our impression was that the instruments did not adequately measure the effect the program had on the peer counselors. This feeling was supported by the results of the final group evaluations held at Saline, Turner, and Ypsilanti. Some samples follow.

1. What did you enjoy about the program?

"Being with the counselors; knowledge on specific subjects; the learning process; training sessions; makes me feel important; I'm making a contribution; being a small part in everything; a feeling of accomplishment; doing something worthwhile; helping my community help itself; everything."

2. What did you learn?

"A lot; that we can do a lot for ourselves and don't have to rely on doctors; the importance of diet and exercise; how little we knew before; how to develop an understanding of feet; all about bones; finding out that there is help, you don't have to suffer; specific information from experts; other people need a lot of love and care and will respond to our attentions."

3. What did you gain personally?

"To listen to what other people said; to talk, speak up; better understanding of my own personal problems; adjustment to blindness, family problems, and growing older; empathy for those with physical problems; a sense of being worthwhile, you don't have to be useless; a concern for the

welfare of others; that I am not unique, many of us have the same problems; something to remember."

When asked if the peer counselor group was different from other groups they had been in, all three peer counselor groups (meeting separately) answered with a strong "yes". Their reasons for this focused on three points: (1) the emphasis on learning, on getting a deeper understanding of important issues, (2) the experience of the peer counselor group itself, the meetings which were described as relaxing, enlightening, "We got more out of it than those who came to the monthly workshops," and (3) the structure of the program, "I had more individual freedom, more choice to do what I wanted, I could use my own power more effectively, we were working toward something, we had a purpose." There was a clear differentiation in all three groups between this group and the usual senior citizen program which several said they wouldn't want to be involved in. Some said it was because the focus was on health maintenance, others felt it was because they were expected to do this themselves and were not "waited on." Most programs, one woman said, concentrate on one thing, "We do everything."

The relationship between staff and counselors and among the counselors emerged as a strong point of the experience. "We were the ones who made the program, you brought out the best in us," a Saline counselor said to general agreement. People mentioned repeatedly that the staff and counselors functioned as one unit and that they enjoyed working with younger people. The Turner peer counselors, especially, noted growth in their relationships with other peer counselors; the other two groups felt strong attachment, a special closeness and ease with each other. People at the Ypsilanti and Saline site expressed sadness at the departure of the Turner staff and felt the one difficulty in the program was seeing people leave to whom they had grown close.

Objective 3: To reach a large number of people with differing needs.

Client contacts during the two years of the model project totaled 5,002 (Table 5). This included 43 workshops, 34 small groups, 4 peer counselor groups, peer counselor clients, telephone consultations to clients and families, 2 annual picnics, and 1 health fair. Participants spanned a range of socioeconomic status from a highly educated middle-income group through low-income, elementary school level education. Participants' health status, as well, encompassed the active, healthy "young-old", the frail in the community, and the nursing home resident.

When asked how they had heard about the workshops, participants indicated that they had heard about it from

TABLE 5

Number of Participant Contacts

TURNER	
19 workshops	1,090
1979 picnic	400
1980 picnic	350
Health fair	250
34 small groups	609
2 peer counselor trainings	19
Peer counselor clients	98
Telephone intakes	480
Housing booklet distribution	250
TOTAL	3,546
YPSILANTI	
6 workshops	550
Peer counselor training	9
	559
SALINE	
6 workshops	502
Peer counselor training	14
Family group	15
TOTAL	531
CHELSEA	
Nursing home--6 workshops	117
Retirement home	208
Peer counselor training	6
Peer counselor clients	35
TOTAL	366
GRAND TOTAL	5,002*

*Estimate of total number of participants is over 2,500.

more than one source. Out of twelve workshops at Turner, an average of 49 percent of the participants had seen an announcement in the newspaper. Thirty-six percent heard about them through Turner Clinic, either at another program or by a telephone call. Another 27 percent heard about them through a friend. From the six workshops in Saline, an average of 46 percent of the participants read about the workshops in the newspapers, 15 percent heard about them through the Saline Community Hospital and 29 percent through a friend. Since it was possible that those who read the announcements in the paper also received a phone call, it was not clear which source motivated attendance. It was the opinion of the staff that phone calls by peer counselors and friends were the most influential means of reaching people in Saline.

Objective 4: To provide varying levels of involvement and entry.

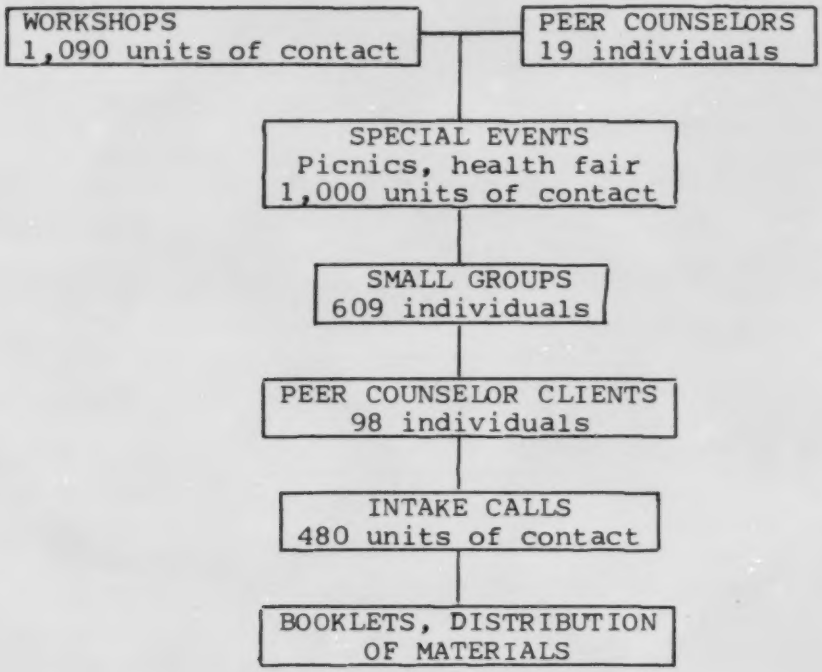
The extent of involvement ranged from attending one workshop, to calling for information about one's aging parents, to involvement in a supportive network of individual counseling or an ongoing small group.

There are really two points presented here: one is the testing of the workshop-peer counselor model in four different population types for a six month period. Based on attendance alone, we have concluded that this is an effective model for reaching the elderly. Based on our workshop evaluations, we also have concluded that the information presented was useful and relevant to a wide range of needs. The pattern of workshop participation in all four sites raised a significant point. Level of attendance varied according to the interest of the topic presented. Over 50 percent at the Turner site attended just one workshop; a small percentage attended all and the rest attended from two to eight. However, at all sites attendance was above what had been considered normal for this kind of presentation. Averages of around 80 at Saline, 70 at Ypsilanti, 50 at Turner, and 20 at the nursing home included a high of over 100 a few times and a low of 30 at the three non-institutional sites. We think this represents a different approach from one in which the goal is to provide services regularly to the same group of people. The Peer Support System aims to make its services available to people as they need them with the hope that amid the offerings will be something that will speak to the needs of all segments of the older population (and their children as well).

The second point is the extension of the original model beyond the six-month period, represented by the Turner site. It is in this expansion of the program, which is currently being planned in the Ypsilanti and Saline sites now

that the base has been established, that the strength of this kind of flexible system can be seen.

TURNER PROGRAM*



The largest number, participants in the workshops and special events, primarily represented people who came on their own as a result of newspaper publicity or word of mouth. A smaller percentage were those who were brought by adult children or, in the case of the picnics, by nursing home staff. Small group participants were more likely to be referred by social workers, physicians, relatives or friends. Rarely did they call on their own. Publicity generated from the workshops thus filtered down to create awareness of other entry levels into the system. The existence of the peer counselor group provided a mechanism for expanding these services.

Objective 5: To provide a link with community resources.

The program served as a bridge between older people and services offered in the community, first, by offering a

*From 10/78 - 10/80

variety of speakers from community agencies and organizations. The speakers not only gave first-hand information on the services they represented, but they narrowed the gap between knowledge of services and utilization of them. For example, a dietician at the Saline Community Hospital spoke at the nutrition workshop and invited participants to consult her. Shortly afterward, she received a number of calls. An exercise instructor saw a marked increase in participation in her weekly exercise groups after speaking at workshops at Turner and Saline. Podiatrists, pharmacists, and physicians in various specialties provided the audience with a starting point for asking about community services.

The small groups also brought participants in closer contact with community resources. For example, the low vision rehabilitation classes offered by the Greater Detroit Society for the Blind were a direct result of efforts made by members and staff of the Low Vision Support Group. The Detroit Society has become a familiar resource to participants and staff. The Newcomers Group collected information on all sorts of community activities as a way of introducing new residents to community life. This group not only discussed the resources but made field trips as a group to several of them.

The peer counselors were very important in bringing resources to clients of the program. Inservice training kept them up-to-date with services and introduced them to key people. Counselors were able to connect their clients with legal services, food stamps, and other income maintenance programs in this way.

Gathering available literature on specific topics, distributing them at workshops, and displaying this material at the clinic brought the best available information to the consumer. In one case, a compilation of housing available to senior citizens in the area was put together by peer counselors and students because a need was seen for it during preparation for the housing workshop. This booklet was widely distributed and has been updated.

Another unexpectedly important way of linking services has been through telephone referrals (see Table 6). Calls have come from all over the state and out-of-state asking for services for the elderly. We have gotten questions such as, "My mother is coming home from the hospital after a stroke. She can't live alone, I'm out of town. Where can she go besides a nursing home?" Or, "We have an elderly friend who is losing his memory but would never call you himself. What can we do for him?" Only a minority of the calls involved asking for specific services, such as snow shoveling or chore services because, we suspect, there are other

referral agencies in the area more suitable for this purpose. Our callers were more apt to want to discuss their problems with another person and were often referred for a subsequent visit to project staff, peer counselors, or other appropriate sources.

TABLE 6

Intake Telephone Calls: March 1980 - July 30, 1980

REASONS FOR CALLS

1. Families/friends calling about parents or relatives because of problems with:

Memory loss	5
Vision loss	4
Drinking	2
Depression	1
Care of wife	1
Care of mother	3

2. Calling for self:

New in community	1
Travel information	1
Hearing services	1
Health services	1

3. Agency person calling for services for their clients 5

4. Students 2

WHERE REFERRED

1.	Turner Clinic	8
2.	Child and Family Services	2
3.	Out-of-town agencies	5
4.	RSVP	1
5.	Phone counseling	4
6.	Home counseling	2

Only 31 calls were recorded; this did not include calls to the receptionist requesting information about workshops or small groups. A probably estimate of calls would be 20-30 per month.

CONCLUSIONS

In summarizing evaluation findings and the experience of the staff, we offer the following conclusions regarding the Peer Support System:

1. The out-patient medical clinic is an effective setting for reaching a significant number of older people with varying needs.

2. A health-focused program offers a non-threatening atmosphere in which psychosocial concerns may be addressed.

3. Peer counselors provide the impetus for planning and organizing an effective, flexible program as well as filling a unique role in service delivery to their peers.

4. Working as peer counselors effectively utilizes the skills and talents of older adults and provides opportunities for development of their skills, continued growth, and contributions to the community.

5. The model of informational workshops and peer counselor involvement can be adapted successfully in settings as diverse as a university town, a rural community, a nursing home, and a nutrition site in a low-income area.

6. The Peer Support System model, through its flexibility and open structure, sets up a framework within which a network of support services can be developed that are relevant to the needs of the older population.

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GUIDELINES FOR RECRUITING PEER COUNSELORS

1. Become familiar with the site and the important people working there. Examples: Nutrition site manager, community service director of a hospital, activities directors in nursing homes.

2. Plan a presentation to community groups illustrating the program. If possible, use peer counselors trained in other sites, in the presentation. If this is not possible, present your ideas clearly and illustrate them with a discussion of some of the issues you hope to cover in your workshops. Ask the audience what health topics (memory changes, arthritis, hearing problems) they would like more information about. Explain that you would like several older people to work with you on these programs so that the material presented will answer most of the important questions. Do not go into the role and responsibilities of the peer counselors with the large group. Ask people who are interested to leave you their names and you can contact them later.

3. Ask the people at the site who have a position of trust with the elderly to talk to potential peer counselors and recommend them for the program.

4. Talk to other professionals in the area who have contact with the elderly for similar recommendations.

5. Write a press release for local papers and monthly senior citizen newsletters and church bulletins; announce your program and invite interested people to call you about becoming peer counselors.

6. Have an interview with each potential peer counselor; outline the program; give a clear idea of time commitment and responsibilities.

7. Write a letter thanking the new peer counselor for joining the program; review briefly the goals of the program; set a time for the next meeting or first training session.

LETTER TO PROSPECTIVE PEER COUNSELORS

Dear _____,

The program we are beginning at the Saline Community Hospital is part of a two-year project funded by a grant from the Administration on Aging from October 1978 to October 1980 under the direction of Ruth Campbell, M.S.W. The project goals are both to provide health education for older people and to involve older people in the creation and maintenance of these programs. The seniors who are involved in this second goal are called peer counselors, older people with a special interest in working with others. They provide support and guidance which helps in coping with the many changes that can come with aging. Peer counselors plan monthly health education programs on a variety of topics from arthritis to stress. They help with publicity, spreading the word about the programs. And then on the day of the program, they introduce guest speakers, help make those who come feel welcome, and lead small discussion groups.

The project originated from the Turner Clinic, University of Michigan Hospital, but the grant provided for it to be extended to other areas as well. We have just completed the project at the Chelsea Methodist Retirement Home and are beginning in Ypsilanti. Saline is our third site, a rural community.

Together we will be planning and presenting a series of six monthly health education programs beginning in February. Since each of our communities has many talented people, the program speakers will come from all of our areas. We will decide on the topics according to the interests of those who come to the first program.

In addition, the grant provides that the peer counselors may choose to accept a stipend of up to $50.00/month ($2.90/hr. for 17 hrs./month). Some may choose not to accept the stipend but to become RSVP volunteers, and therefore, can receive travel reimbursement from RSVP.

As a group we will plan the programs, publicize them, and help on the day of the presentation. As peer counselors this will mean one meeting a week until we get acquainted with the ins and outs of putting on the programs. But equally important is the chance to get to know each other. The Turner peer counselors have often said that it is the stimulation and enjoyment of each other as much as the actual programs that means so much to them. The weekly meetings will include the

nitty-gritty work as well as some on-going classes and discussions so that we gain the necessary skills and experiences to carry on the project. If you like the programs and the community likes them, then we want to be able to have them continue. The ultimate intent is that through this experience we will have begun an important and interesting program that will continue well beyond six months.

We invite you to become a peer counselor because of your ability to work with people. If you are interested or would like more information, call _____. We hope you will join us.

Sincerely,

_____

PEER COUNSELOR CONTRACT

NUMBER OF HOURS PER WEEK I PLAN TO WORK _____

DAYS AND TIMES I PLAN TO WORK _____

_____

_____

I WILL BE DOING: __ WORKSHOP PLANNING __

__ INDIVIDUAL COUNSELING __ PUBLICITY

__ OTHER _____

I PREFER TO USE: __ TELEPHONE __ HOME VISITS __ CLINIC

I PREFER TO WORK: __ ALONE __ WITH ANOTHER PEER COUNSELOR

PROBLEMS I WANT TO WORK WITH: _____

_____

_____

_____

PROBLEMS I DO NOT WANT TO WORK WITH: _____

_____

_____

_____

SIGNATURE _____

PEER COUNSELOR TRAINING SESSIONS

SESSION I Monday, July 23 GETTING ACQUAINTED

1. Purpose of Training
2. Description of Program

SESSION II Wednesday, July 25 WHAT ARE PEOPLE FEELING?

1. Identifying Feelings
2. Responding to Feelings
3. What Am I Feeling?
4. Referrals--Susan Sweet, Tony Scott, Washtenaw Council on Aging

SESSION III Thursday, July 26 WHAT ARE PEOPLE SAYING?

1. Identifying Content
2. Separating Content from Feeling
3. Understanding Unspoken Communication

SESSION IV Monday, July 30 CHANGES WITH AGING

1. Discussion of Changes (retirement, death, etc.)
2. Ways To Help

SESSION V Wednesday, August 1 GROUPS

1. Beginning, Ending, Middle of Groups
2. What To Do with Disturbances Such As People Talking Too Much
3. How To Draw People Out

SESSION VI Thursday, August 2 WRAPPING UP

1. Continue Discussion on Groups
2. Peer Counselor Roles--What Would You Like to Do? How to set limits and priorities on your involvement with the program
3. Summary of Training Sessions

PEER COUNSELOR TRAINING EVALUATION

1. What did you like best about the training?

2. Which session did you find most helpful?

3. What did you not like about the training?

4. Would you suggest a longer or shorter training? Why?

5. What are your suggestions for future training?

Comments:

GUIDE FOR PEER COUNSELORS:

WAYS YOU CAN HELP

1. Listening--giving a person time to talk.

2. Understanding--saying that we understand what it is like to feel sad or angry or afraid.

3. Praising--acknowledging what a person has done or is doing that shows strength.

4. Encouraging--recognizing a person's strengths and suggesting that these strengths can help with this problem too.

5. Reassuring--saying that others have experienced the same, "You are not alone."

6. Caring--showing that we care by non-verbal expressions of interest and concern as well as by words.

7. Giving information.

GUIDE FOR PEER COUNSELORS:

INDIVIDUAL COUNSELING

The following questions may help you in clarifying a problem:

1. What is concerning (bothering) you?
2. How long has this been a concern?
3. Has a similar thing ever happened before?
4. How did you handle it before?
5. Who are the people that you turn to for help?
6. In what ways can these people be of help now?
7. What would make your situation less difficult?
8. How do you feel I can help you?
9. Is there anything else that would help me understand your concerns/situation?

GUIDE FOR PEER COUNSELORS:

CLIENT NEEDS ASSESSMENT INSTRUCTIONS

Goal of Assessment:

1. Assess the client's present functioning in his/her home.

2. Delineate strengths and problems.

3. Determine whether problems are amenable to intervention through supportive community or family services within or outside of the Turner Clinic.

At End of Assessment:

1. Summarize results giving the facts on assessment form.

2. After consulting with supervisor make plan with client to meet needs.

3. Write a summary of your impressions and give to your supervisor.

At this point, this assessment will be used with Turner Clinic patients who have requested a home visit and/or further non-medical services or who the medical team has decided need such services. It has been decided that a relationship can be established and an assessment of need made by a volunteer counselor, preferably an age peer.

Each counselor will approach a client in his/her own way. Some suggestions however may be useful:

1. The establishment of trust and a friendly relationship is essential.

2. There is not necessarily a rush to get this information. It may take many visits.

3. The client should be approached on the basis of the request he/she has made for service. That should be handled first.

4. It is desirable that where possible, information should be ascertained by observation rather than direct questioning.

5. Where questions are asked and answered, it is desirable that they be verified by observation or consistency of answer.

6. The assessment areas have been presented with the least threatening subjects first. However, the counselor can follow any order that seems natural.

7. The assessment contains information we'd like to gather. The counselor should decide how to ask for this information. Some sample questions are included.

8. If at any time you have concerns about your visit or your client, and you need to discuss the situation with someone, you should contact Barbara Chenoweth at the Turner Clinic, 764-6831.

GUIDE FOR PEER COUNSELORS:

CLIENT NEEDS ASSESSMENT FORM

NAME _____ AGE ____ NUMBER IN FAMILY ____

ADDRESS _____ PHONE _____

1. ACTIVITIES OF DAILY LIVING — Sample suggestions:

a. Dressing, Bathing, Grooming — "Describe your day."

1. Able to manage alone

2. Needs some help

a. help available
b. help not available
c. more help desired

b. Routine household management--laundry, cleaning, repairs

1. Able to manage alone — (Try to observe whether answers are correct)

2. Needs some help

a. help available
b. help not available
c. more help desired

c. Cooking — "What did you cook for yourself yesterday?"

1. Able to manage alone

"How do you get your shopping done?"

2. Needs some help

a. help available — (Try to observe if food is in the refrigerator)
Meals on Wheels
Shopping assistance
b. help not available
c. more help desired

d. Observe client carefully: general appearance, grooming, appropriate clothing, etc.

2. HEALTH

a. Describe state of health

b. Name of physician
Phone number

c. Any serious health problems or physical disabilities?

Is "Vial of Life" in refrigerator

d. Hearing

e. Vision

f. Medications taken, for what?

(Try to look at medicine chest to see where they are stored. Note dates and amounts of medicines.)

g. Which over counter drugs are used?

h. Level of alcohol intake daily; weekly

i. Home Health Service used (Visiting Nurses, home health aide)

j. Home Health Service needed (Describe)

"Do you have any health insurance like Medicare or Medicaid?"

k. When were you last in a hospital?

3. HOUSING--What are living arrangements?

a. Enough room--too much

"Who lives here with you?"

b. Heating adequate? yes no

c. Plumbing, sanitation--repairs needed

d. Describe hazards:

"Is telephone located near the bed?"

1. Slippery rugs, loose handrails, etc.

2. Inadequate lighting

"Do you listen to TV or radio for information? Do you know the warning signals?"

3. Can manage steps (that are used)

4. Safe neighborhood? (Dial 911 for emergency help) — "Do you have any concern about going out alone?"

e. Wish to share housing? yes no

f. Have you received your tax credit?

g. Have you received utility allowance?

4. PSYCHO-SOCIAL AREAS

a. Regular activities and interests — "What do you do for fun and relaxation?"

b. Satisfaction with level of social activities (i.e., church, cards)

c. What people does he/she see--how often (i.e., family, friends, neighbors)?

d. Satisfaction with amount of contact with friends, family

e. Are there conflicts in family?

f. Have there been recent losses (spouse, family, friend)?

g. Are there feelings of nervousness, blues, isolation?

h. Any recent changes in memory?

i. Do you ever wish to talk things over with someone?

j. Who do you go to if something is troubling you?

k. Have you ever contacted a physician or agency about any of the above?

l. Do you have any concern(s) that we have not discussed?

5. TRANSPORTATION

a. How often needed?

"How do you get to your appointments?"

b. Available

1. Always, sometimes, seldom

"How often do you get out of the house?"

2. Types used

3. Needs information

6. FINANCIAL NEED

a. Adequate income for needs?

"Do you have enough money to cover your expenses?"

yes no

b. Problem budgeting rent, utilities, telephone?

yes no

c. Meeting health expenses?

yes no

d. Meeting drug expenses?

yes no

e. Approximate monthly income:

___ less than $250

___ 250 - 400

___ 401 - 500

___ 501 - 600

___ 601 - 800

___ 801 - 1000

___ 1000 - 1200

___ more than $1200

For low income: Is he/she receiving food stamps, SSI?

SUMMARY

What are the client's strengths and what are his/her unmet needs?

GUIDE FOR PEER COUNSELORS:

CLIENT NEEDS ASSESSMENT RECORD

NAME _____ AGE _____

ADDRESS _____ PHONE _____

REFERRED BY _____ MARITAL STATUS _____

LIVING SITUATION: ALONE COUPLE FAMILY RETIREMENT HOME OTHER

INCOME LEVEL: BELOW 3,000 $3,000-$5,000 $5,000-$10,000
ABOVE $10,000

SPECIAL NEEDS _____

_____

_____

MISC.

DATE	PROBLEM	PLAN	COUNSELOR

EXAMPLES OF INDIVIDUAL COUNSELING

BY PEERS OVER A TWO-YEAR PERIOD

Drinking problems	3 clients
Mental confusion	4 clients
Low vision	25 clients
Vision - general problems	3 clients
Nursing home problems	2 clients
New to Ann Arbor	3 clients
Loneliness	10 clients
Housing problems	1 client
Mental health follow-up	1 client
Trouble filling out forms	1 client
General health problems	3 clients
Meal planning help	1 client
Depression	3 clients
Homemaker needed	2 clients

GUIDE FOR PEER COUNSELORS:

DISCUSSION GROUPS

Two peer counselors should decide ahead of time what each will do during the group discussion.

At the beginning of the group:

1. Introduce yourself to the group.

2. Say what the group will be talking about: e.g., "For the next 20 minutes we will be talking about what bothers you about your heart."

3. Say that you would like each person to have a chance to talk.

4. You can begin the discussion by saying what bothers you about your heart.

During the group:

1. Give each person a chance to talk.

2. Show interest in what is said.

3. You can ask a person to say more about what he/she said.

4. If you don't quite understand what was said, ask if the person could say it again.

5. Hopefully what one person says will cause another person to say something else.

6. If someone talks too much, say it's interesting to hear from him/her but we'd like to hear from others too, or say we can talk to him/her more after the group is over.

At the end of the group:

1. Before the group is over, you can summarize what people have generally said: e.g., "... most of us are worried about how to prevent a heart attack and how much exercise we should have," etc. "... we will ask the doctor about these things."

2. Thank everyone for contributing to the discussion.

GUIDE FOR PEER COUNSELORS:

SAMPLE GROUP DISCUSSION QUESTIONS

TO GROUP LEADERS: It is unlikely that there will be enough time to cover all these questions. If the group is particularly interested in one or another of the questions let them take time on it. If someone brings up a problem or a question beyond the scope of the group the recorder should take down his or her name and address and the staff can follow up on it later.

1. In which of the discussed areas do you have problems? Have you had any in the past?

2. What did you do about the problem?

3. In what ways do you feel the present standards of consumer protection are adequate or inadequate?

4. What do you usually do when you are dissatisfied and want to make a complaint?

5. How do you get support from other people if you want to change something or do something different?

6. How can we make others aware of some of the issues discussed today?

WORKSHOP PLANNING CHECKLIST FOR PEER COUNSELORS

Workshop Planning Committees are composed of peer counselors and one staff member who divide the following tasks among themselves:

TWO MONTHS BEFORE THE WORKSHOP

1. Based upon your interest, select a workshop to help plan.
2. Meet with the planning committee.
3. Committee should discuss workshop objectives:
   A. Define what information you want the workshop to cover;
   B. Begin to explore possible speakers, talk to people in the field.
4. Discuss workshop objectives and plans with total peer counselor group and incorporate its ideas into the committee plans.
5. Committee should choose speaker(s).
6. Talk to each speaker:
   A. Ask what ideas speakers have about workshop;
   B. Explain what you would like accomplished at workshop;
   C. Describe who comes to workshops;
   D. Explain workshop format (how long person is expected to speak, time for questions, etc.);
   E. Encourage speakers to bring materials about their programs.
7. Committee should try to gather booklets and other information on the topic.

ONE MONTH BEFORE THE WORKSHOP

8. Send letter to speakers confirming workshop date and include any specific instructions.
9. Begin publicity.
10. Make room arrangements.

TWO WEEKS BEFORE THE WORKSHOP

11. Telephone key people to remind them about the workshop (nursing homes, retirement centers, nutrition sites, etc.).

12. Remind publicity committee that announcements for the workshop should be sent to daily papers and radio stations.

13. Prepare workshop program.

14. Make sure evaluations are ready to be handed out.

ONE WEEK BEFORE THE WORKSHOP

15. Call speakers to remind them of the date and time.

16. Committee should meet to decide:

    A. How to introduce speakers, get name tags for speakers;

    B. Arrange transportation for participants, if possible;

    C. Sign peer counselors up for specific jobs.

DAY OF THE WORKSHOP

17. Make sure everything is set up:

    A. Rooms in proper order;

    B. Registration materials ready;

    C. Sound equipment (microphone, etc.) ready;

    D. Evaluations ready to be handed out and collected.

FOLLOW UP ON THE WORKSHOP

18. Thank you notes should be sent to all speakers.

19. Evaluations should be compiled.

20. Discuss how the group wants to follow up on people that are interested in further information.

SAMPLE TOPICS AND OUTLINES FOR WORKSHOPS

NURSING HOME SETTING

1. "Remembering" Speaker: Turner Clinic Social Worker

   Main ideas: We remember what is important to us; remembering can be a problem because of overload with passing years.

   Discussion aids: A table with a variety of objects that stimulate recall of memories to look at, pass around, touch, and smell.

   Take home: A date book with future programs marked. Donated by local gift shop.

2. "Arthritis" Speaker: Turner Clinic Nurse Clinician

   Main ideas: The different kinds of arthritis and what to do to live with arthritis.

   Discussion aids: Chart to show changes in joints; demonstrate and pass aids, i.e., long-handled sponge for washing, long-handled hair brush, etc.

   Take home: Booklet about arthritis by Geriatric Arthritis Project, The University of Michigan.

3. "Exercise" Speaker: Graduate Student, Educational Gerontology

   Main ideas: How exercise affects the body and circulation; ways to incorporate exercise into daily routine, i.e., washing, stretching.

   Discussion aids: Use music to practice exercises in the group; peer counselor demonstrates exercises as she gets up from bed; use hand lotion for each person to massage neighbors' hands.

4. "Bladder Problems of Women" Panel: Turner Clinic Nurse Clinicians and Psychiatric Nurse

   Main ideas: Kinds of bladder problems and how to handle them with emphasis on how common a problem this is for women.

Discussion aids: Slides of anatomy; pictures to illustrate bladder problems; schedule for figuring out individual patterns of urinary incontinence.

Take home: Booklet about hygiene from Clinic.

5. "Eyes" Speaker: Optometrist, University of Michigan Low Vision Clinic

Main ideas: Visual aids can alleviate some of the limitations caused by poor eyesight.

Discussion aids: Table with visual aids from Library for the Blind and Physically Handicapped, pass aids.

6. "Hearing" Speaker: Audiologist, University of Michigan, Department of Speech and Hearing.

Main ideas: How hearing can change with aging; how to make yourself understood to those who are hard of hearing.

Discussion aids: Pictures of anatomy of the ear; group size limited to ten people.

Take home: Handouts of main points of discussion prepared by speaker.

HOSPITAL, NUTRITION SITE, CLINIC SETTINGS

7. "Taking Care of Your Heart" Speaker: Cardiologist, University Hospital

Main ideas: What causes heart problems, the role of nutrition and exercise, what medical intervention can do, how to live with a heart problem.

Discussion aids: Slides to illustrate the heart and how damage occurs. Pass around a pace-maker.

Take home: Booklets from the Michigan Heart Association.

8. "Diabetes and You" Speaker: Nurse Clinician, Diabetes Clinic, University Hospital

Main ideas: What causes diabetes, who should take insulin and when, what foods should be eaten, what exercise is appropriate; how to live with the diabetic patient; self-management by the diabetic.

Discussion aids: A film on foot care for the diabetic patient. Resources for diabetic care discussed.

Take home: Booklets from the American Diabetes Association.

9. "Eyes and Ears" Speakers: Audiologist, University of Michigan; Opthamologist working in Ypsilanti

Main ideas: What causes hearing problems in old people and what should be done about it. How to buy a hearing aid--how much it should cost and how to get used to it. What causes buzzing in the ears ("tinnitis") and use of masker which cuts down noise for many patients. What causes cataracts; when should they be operated on? What is glaucoma and how do you know you have it. Eyes do not wear out if you use them a lot.

Discussion aids: Pass around tinnitis masker and several hearing aids for people to look at one at a time. Recommend artificial tears if eyes are irritated and dry.

Take home: Literature from audiologist on common hearing problems and advice on purchase and use of hearing aids.

10. "The Golden Years" Speakers: Four peer counselors from Ypsilanti

Main ideas: Each peer counselor speaks on his/her experiences in growing older--how earlier years influence feelings about old age; hopes for the future, faith in God, need to remain involved in life.

Discussion: Audience response--tell their experiences: past struggles, benefits of coming to nutrition site, and religious beliefs.

Take home: Tapes of the session.

11. "Nutrition" Speakers: Nutritionist, University of Michigan

Main ideas: Nutritionist describes the digestive process in older adults, what changes occur and the result of these changes. Cholesterol, how it is produced and the need to have one's physician do tests to discover whether cholesterol is an individual's problem.

Discussion aids: Chart of digestive system to facilitate answers to questions about diets, eating fatty foods and how much diet contributes to cardiac problems and strokes.

SAMPLE TOPIC CHECKLIST FOR WORKSHOP PARTICIPANTS

Dear Workshop Participant,

In order to plan workshops that are interesting and helpful for your, we need your input. Following is a list of possible topics for 1979-80 workshops. Please read them all over and check off the ones that would most interest you. Please write in your own suggestions also. We hope to see you in the coming year!

___ Housing
___ You the Consumer
___ Diabetes
___ Legal Aid:
  ___ Guardianship Proceedings
  ___ Rights of Nursing Home Residents
  ___ Landlord/Tenant Problems
  ___ Divorce
  ___ Special Tax Benefits
  ___ Probate Proceedings
  ___ Wills and Trusts
___ Taking Care of Your Finances
___ Stress
___ Arthritis
___ Winterizing Your Bones
___ Eyes and Ears
___ Dental/Peridontal Care
___ Ways to Cope with Headaches and Other Pain
___ Aging and Sexuality
___ Other

___ Taking Care of Your Heart
___ Cardiopulmonary Resuscitation
___ Widowhood
___ Fire Prevention
___ Emergencies and Household Safety
___ On Death and Dying
___ Security in Your Home
___ Crime Prevention
___ Nutrition
___ Health Foods
___ Things to Do in Your Room
___ Men and Women: Aging Differences
___ Being Single
___ Transportation
___ Retirement Communities
___ Eating Alone
___ Being Practical About Fashion
___ Family Relationships

_____

_____

_____

_____

SUGGESTIONS FOR SPEAKERS AT NURSING HOME

These suggestions are drawn from our experiences with a series of health care presentations. They are meant to help you in planning your talk for nursing home residents. Because many residents have vision and hearing problems, they often do not give the usual non-verbal cues that let you know you are being understood. Sensory problems can mistakenly give the impression that mental comprehension is lacking. Be certain that the sound system is working adequately. After that assurance, it is best to assume that you are being understood. The following guidelines will further assure that you are being heard and understood.

1. Prepare your presentation to last 30-45 minutes.

2. Decide on a few important ideas.

3. Communicate these ideas in a variety of ways, i.e., demonstrations, pictures, slides, or other teaching aids.

4. Encourage resident participation, i.e., group activities, passing things around, or stimulating discussion and comments.

5. Speak slowly.

6. Speak clearly.

7. Repeat questions and comments so that others can hear, i.e., "Mrs. Smith just asked if ..."

8. Use microphones and sound equipment as suggested and set up.

9. Handouts are very helpful.

SAMPLE PRE-WORKSHOP LETTER TO SPEAKER

Turner Geriatric Clinic
1010 Wall Street
September 2, 1980

Dear Dr. Wolter,

We are very pleased that you will be speaking at our workshop on the care of the eyes on Thursday, September 18 from 1:00 - 1:15 P.M. As we discussed on the phone, we would like you to talk about how to take care of the eyes to prevent problems as well as new developments in the treatment of eye problems. Since people usually have many questions, it would be best to plan your presentation for a half hour and allow 30-45 minutes for questions and answers. We have planned your total time to be an hour and 15 minutes. After your talk there will be a short break and then a panel discussion of older people talking about the ways they are coping with limited vision in their everyday lives. I hope you will feel welcome to stay if your schedule permits.

We expect 50-70 senior citizens for the workshop. A microphone will be available since many have a hearing problem. It is also helpful if you repeat any question asked so everyone can hear it.

We are looking forward to your presentation. Please call if you have any questions or need assistance in any way. 764-6831.

Sincerely yours,

Barbara Chenoweth, R.N., M.S.
Program Coordinator

SAMPLE THANK YOU LETTER TO SPEAKER

Turner Geriatric Clinic
1010 Wall Street
764-6831

Dr. Jerome Epstein
102 Arnet
Ypsilanti, MI 48197

Dear Dr. Epstein:

Please excuse my delay in thanking you for your excellent presentation at our Willow Run workshop. As always, the information you gave and the wonderful way in which you delivered it met with an enthusiastic response. One woman tells me whenever we meet now how much she learned that day (she's the "artificial tears" lady).

Barbara Chenoweth will be in touch with you in the near future about plans she's been making to try to expand the low vision support group program and look for funds to support it. We appreciate all the assistance you've given us with our program and hope we can work together in the future.

Sincerely,

Ruth Campbell, M.S.W.

WORKSHOP PRESENTATIONS BY PEER COUNSELORS

"... My Life As I Grow Older"
by Dorothy Miller, Peer Counselor

First of all, before Ruth begins timing me I want you to know that I'm real nervous about this little talk. I'm nervous because I feel deeply about the things I'm going to say and I'm afraid I won't say them right.

Also, before we get into the nitty gritty I'd like you to know that the things I'm going to say--should you want to incorporate them in your thinking--won't cost a cent, but I sort of think that they will bring us joys which no money can buy.

Now to the root of things. Over the years I have known older people that I've loved and admired. Others have told me about their older friends that they also have loved. Together we've tried to determine what the characteristics were of those dear people. After we determined what those features were, I said to myself, "Those are the things that I want to incorporate in my life as I grow older."

These are some of the characteristics that I have observed.

First, and quite foremost, I want to keep flexible. I had a dear father-in-law who, each morning had to have porridge and that porridge had to be in the blue-bird bowl and eaten with one particular spoon. Without those his breakfast was ruined. He forgot that the <u>important</u> thing about the breakfast was WHAT WAS IN THE BOWL--not the things that held it.

As we grow older and things around us change and we say sourly, "Things are certainly not what they used to be," we better remember to look open-mindedly at the present. See what's in that bowl that's really good. Be willing to be flexible about the truly important things. After all, the world keeps turning, you know. It isn't going to help if we put our head in the sand and fall off the earth. Let's not always do the things we've always done. Let's shake ourselves up a bit and do something different. Keep flexible.

Secondly, this important word is <u>listen</u>. <u>Listen</u> to your children and your grandchildren. <u>Listen</u> to your friends and acquaintances. <u>Listen</u> to youth.

I've had two important experiences which taught me about listening. One came through our son. We used to have wonderful talks and I listened. He told me what he and

youth were thinking and why they found the things in their porridge bowl that were important. These things were different but they were thoughtful and they were good. Because I listened we understood each other and it has drawn us closer and closer together.

The second experience in listening came while I was teaching. In a staff meeting we were talking about a certain student. We young teachers said, "Oh, she's crazy--she's a kook!" Our very wise boss said, "Wait a minute. You don't know all the things that person has gone through. If you had been in her shoes you might be even more peculiar than she."

So let's listen, listen, listen. When you find someone who listens to you as you have listened to her/him--then you've really found a friend.

Thirdly, reminisce, but <u>reminisce with your peers</u>, someone your own age range. Reminisce with others <u>only when asked</u>.

Fourthly, be enthusiastic and daring. Our 80-year-old aunt (whom we adored) was visiting us. I had the once in a lifetime opportunity to go to Portugal but I wasn't so keen about going all alone. We asked her if she would go. Immediately she said, "I'd love to!" She dared to go even at 80 and she loved every minute of the trip.

One day a good friend (also 80) came dashing in saying that she'd spent the night in Ypsilanti with her friend. I say--good for her. She didn't say, "I'd like to go but I can't sleep unless I'm in my own bed." And so, by gracious, I'm going to remember that, too, and I hope I'll go even if I think I won't sleep. I'll just take a little sleeping pill along. Keep up your enthusiasm I say to myself.

Fifth, keep working on your dreams. Do the things you've wanted to do. I've always thought that I wanted to write. Now I say, do it now! Maybe the things that I write will be real dumb. But remember, Grandma Moses became famous when she was 90.

Now is the time to fulfill dreams.

Sixth, don't give in to loneliness. My cousin used to doll up with her best dress and prettiest hat. Then off she'd go to see someone when she got depressed. Or if she couldn't go out she'd call up a friend to come and have tea with a store bought cookie.

As for myself, when I get down I like to go way out in a nearby field and sit under a big shagbark hickory

tree. When I first get there I may cry a little over my plight, but pretty soon I begin listening to the earth sounds--the songs of the birds, the humming of the bees and the soft breezes comforting me. I watch the great Canadian geese flying overhead. Then I began to see many beautiful things both big and little that I hadn't noticed before. Before I knew it I was singing along with all of God's great beautiful world.

Seventh, last but not least. Laugh and laugh and laugh. You all know, "Laugh and the world laughs with you, weep and you weep alone."

If you can't work up a good laugh, at least put on a good smile. You are prettier that way and like the sun, it draws people to you or at least it makes others feel good.

Of course life is serious but let's not take ourselves too seriously. If you have nothing else to laugh at, laugh at yourself. In that connection I have a story to tell ...

"Challenge in the Later Years"
by Bea Wooley, Peer Counselor

When asked which age I would prefer to be if I could "turn back the clock" I chose the late forties or even the fifties. When asked why the answer was easy. Ten days after my sixtieth birthday I was suddenly and unexpectedly a widow. The forties and fifties represented years of security--a husband, a grown son, higher earning years, a vacation home--full and interesting years. Suddenly with the sixties the insecurity of the earlier years had to be faced all over again. Loneliness, reduced income, where to live and all the rest.

So what do you do to make them full and interesting again? First of all I think a lot depends on our early training. If we've been taught to accept adversities as a challenge, believing that every problem we wrestle with and lick will make us stronger and better able to face the next one, then I think we're more apt to recognize being left alone as the greatest challenge of our lifetime and one that sooner or later all married couples face. Even if you've lived in the same community for 35 or 40 years you find your circle of friends changes once you are alone and even the years take their toll as far as friends are concerned. So friends alone are not enough to fill one's later years. We are too accustomed to being an integral part of family life. We soon come to realize that we need the warmth of that family living and too often this means moving to a new community nearer our children.

Where we live must meet two requirements: first, we must have a feeling of security which does come from being closer to family; but secondly, we also need to retain our independence. I think if we can leave our own community and friends before ill health forces us to we are more apt to retain that independence. Also, it helps us to meet two other essential requirements to having a full and interesting life: we must have interests outside of ourselves if we are to avoid becoming preoccupied with our own troubles and we must also become involved in useful activities if we are to give some purpose to our lives and to retain some degree of self-confidence. I feel fortunate that my move brought me to Ann Arbor because here the new interests are unlimited and the possibilities of getting involved in useful activities are endless but I am sure they exist in every community if we just accept the challenge to seek them out. Some people--I think men in particular--can go even further towards living a full life if they can find some worthwhile cause that could have some impact on their environment and here again there are a number of causes just to improve the lives of other senior citizens.

Dr. D.D. Stonecypher in his book on "Growing Old and Staying Young" feels the best solution is to stay employed as long as possible but if you are forced into retirement he recommends you get involved in activities which have the following characteristics:

1. An activity you like or respect.
2. One that won't take more time than you want to give.
3. One that pays if even a little. Payment enhances the older person's self-esteem and forces him to turn in an acceptable performance.
4. One that requires you to exercise skills and overcome problems.
5. An activity that brings you in contact with people who want to talk to you.
6. One that develops new resources, either new skills, enlarged social contacts, or expanded personality traits.

Select projects based on the person you are--not on one you imagine you could become. No one else can choose for you because only you know how depressed you are, how much energy you have, how empty your life really is. I recently ran across this article that seems to express the need to live just for one day at a time, then no challenge is too great.

Just for today I will try to be happy. Abraham Lincoln said, "Most folks are about as happy as they make up their minds to be." He was right. I will not dwell on thoughts

that depress me. I will chase them out of my mind and replace them with happy thoughts.

Just for today I will adjust myself to what is. I will face reality. I will try to change those things which I can change and accept those things I cannot change.

Just for today I will try to improve my mind. I will not be a mental loafer. I will force myself to read something that requires effort, thought, and consideration.

Just for today I will exercise my soul in three ways: I will do a good deed for somebody--without letting him know it. (If he or she finds out I did it, it won't count.) I will do at least two things that I know I should do, but have been putting off. I will not show anyone that my feelings are hurt, they may be hurt, but today I will not show it.

Just for today I will be agreeable, I will look as well as I can, dress becomingly, talk softly, act courteously, and speak ill of no one. Just for today I'll not try to improve anybody except myself.

Just for today I will have a program. I may not follow it exactly but I will have it, thereby saving myself from two pests: hurry and indecision.

Just for today I will have a quiet half hour to relax alone. During this time I will reflect on my behavior and will try to get a better perspective on my life.

Just for today I will be unafraid. I will gather the courage to do what is right and take the responsibility for my own actions. I will expect nothing from the world, but I will realize that as I give to the world, the world will give to me.

In closing, I guess if I were to give my own philosophy on how to grow old and stay young I would say to take a lesson from the little chickadee--he always faces into the storm. If he didn't the chill winds would ruffle his feathers and he'd surely freeze to death. I hope I'm as smart as the chickadee. Are you?

Written for "Younger Than Springtime" Workshop at Turner Clinic, May 17, 1979.

DESCRIPTIONS OF SMALL GROUPS

Women's Group: From Generation to Generation

The Women's Group was made up of ten women from 18 to 85 years of age, with each decade represented. They met to discuss various topics from their different age perspectives and to learn the ways in which they were similar or different.

Eight weekly two-hour sessions were planned, each with specific topics such as:

Aging--how it affects women's lives.

Images of ourselves and our bodies.

Our historical era and our expectations.

Close relationships.

Women and politics.

Women and creativity.

Turning points and transitions.

What we keep from the past; what we take to the future.

To focus discussion, leaders asked participants to contribute something about themselves each week--bring photos, share memories, or describe parts of their personality.

Response was enthusiastic. The group continued to meet on a monthly basis after the original eight weekly sessions ended. A second group, composed of twelve women, also continued to meet beyond the eight weeks. Plans have been made for students in the Women's Studies Department at The University of Michigan to participate in future groups.

Arthritis Support Group

An arthritis support group was established to provide an opportunity for information sharing and problem solving. Discussion covered disease process, use of heat, medication, rest, exercise, and diet. Group members also talked about problems related to daily living and dealt with problem solving for functional difficulties. The group emphasized the principles of joint protection and explored problems of coping with arthritis. Group attendance ran from 8-12 per session. This four session group was offered twice.

Weight Loss Group

The Weight Loss Group was formed at the suggestion of a Turner client. The group met for eight two-hour sessions. Sessions combined instruction by a nutritionist, a discussion of various topics, and sharing of problems. Some members kept a daily food intake record; many were weighed at each session. Fifteen people attended and requested that the group be continued. It has been meeting bi-weekly on a continuous basis.

Memory Group

The Memory Group grew out of repeated requests for more information following a Memory Workshop. Each of seven weekly sessions included a lecture and discussion by an authority on some aspect of memory and also time to practice a memory strengthening exercise. The objectives were to inform people about the normal changes in memory with aging and the effects of drugs, nutrition, disease, and stress on memory. Emphasis was placed on the directions of current research. Techniques to aid memory were adapted to fit everyday life situations, i.e., misplacing keys, forgetting names. Principles introduced each week were carried through to the following sessions. In the concluding session a panel of people discussed how they used their memory in their occupations, such as driving a bus, remembering lines for a play. Attendance grew from 18 to 38. A pre- and post-evaluation was given. Another Memory Group has been planned.

Book Lovers Club

The Book Lovers Club was started for people who enjoy reading and like to discuss what they read. It gave the members an opportunity to exchange ideas for further reading and to exchange books. Initially it had 15 members with an average attendance of 8. At one meeting an Ann Arbor author, H. Ladia Stewart, spoke and read some of her work. At the final meeting another author, Hazel Littlefield Smith, invited the group to her home and discussed her life and works. The group met monthly.

French Conversation Club

This group was initiated by a woman who read and tutored several languages and was interested in keeping up her skill in French. Four to six people met every other week with a brown bag lunch to speak to each other in French. The leader sometimes read a short essay from a book to help get the group started. Members were recruited through newspaper publicity and a local French-speaking group associated with the University.

Spouses Group

The purpose of this group was to provide information and support to husbands and wives whose partners required a great deal of attention or care. Four sessions included: balancing your partner's needs with your own, taking time for yourself; short trip opportunities and overnight care resources; legal issues related to nursing home care; and legal matters related to wills and guardianship. Fifteen men and women attended with an average attendance of five.

Rhythmic Exercise to Music

An Associate Professor of Physical Education at The University of Michigan has been conducting this group for two years. It serves as a practicum for her students during the school year; for the past two summers, several of these students have led the group. The meetings last an hour and a half without a break and all exercises are done to music. The music provides a relaxing atmosphere that allows older people to exercise every part of their body without feeling pain or tightness. Participants (about 25 attend weekly) report being less tired, having lower blood pressure, and feeling generally healthy. After two years of continuous weekly classes, the program was increased to three classes per week.

Sleep and Relaxation Groups

Two separate groups (Sleep--four weeks; Relaxation--six weeks) focused on relaxation techniques to help relieve tension, anxiety, and aid in preventing insomnia. The Sleep Group was led by an exercise specialist and concentrated on practicing progressive relaxation and other exercises to relieve tension. The Relaxation Group, run by a social worker, was more like a discussion group in which people talked about the kinds of things that produced their anxieties and supported each other in working out solutions. The leader also guided the group in the use of fantasy as a way to ease tension. Eight to ten members participated in each group.

Writing Groups

Two writing groups have been meeting weekly, one for two years, the other for three years. Composed of fourteen members each, the groups enjoy the writing and company of each other, encouraging one another to write their stories and experiences. Although the emphasis is not on writing technique, some people ask for suggestions on style and others work on projects intended for publication. Group leaders may suggest topics to write about, but members often write from their own ideas.

Hearing Groups

Four Hearing Groups have been jointly sponsored by Turner and the Communicative Disorders Clinic. Students administered free hearing tests, provided information on hearing aids, taught lip-reading and ways to improve communication. Attendance has varied from eight to twenty-five people. The groups met for six weekly sessions.

Low Vision Support Group

Ongoing, monthly meetings have provided over 50 people with information on community services and visual aids. Members have shared their own experiences, exchanged ideas, and invited speakers so that they could learn how to accommodate decreased vision without losing their independence. This group has been meeting for two years through the leadership of two peer counselors, one of whom is legally blind. Programs have included legal issues, nature appreciation (including a nature walk), practice in making holiday gifts, and discussions of eye care.

Low Vision Classes

Taught by the Greater Detroit Society for the Blind, the classes focused on daily activities such as handwriting, mobility, sewing, make-up, and handling money. Fourteen people attended the bi-monthly sessions for six months. Plans have been made for the classes to be held again.

Newcomers Group

Four Newcomers Groups have met under the direction of a peer counselor who felt such a group was needed for older people moving to Ann Arbor to be near their children. Membership has averaged 12. Six weekly sessions introduced people to each other and to services and opportunities in the community.

Friday Morning Group

For the memory-impaired elderly, this group met weekly for two years. Ideas for the sessions were developed by a peer counselor and graduate students and included discussions of current events, adult games, movement to music, art, and occasional trips. Average attendance was six.

Family Groups

Two family groups met for six sessions each to assist members, through speakers and discussions, with decisions regarding the care of aging relatives. Emphasis was placed on improving family relationships. Eight to ten people participated.

Family Support Group

Initiated by a Saline peer counselor, this group was offered to families of residents of the Saline Evangelic Nursing Home. Fifteen people attended four weekly sessions. Topics included members' feelings about having a relative in the nursing home, ways to cope, who to go to in the nursing home with a problem, and how to continue to contribute to the well-being of a relative. The group asked that the meetings continue on a monthly basis.

SAMPLE GROUP NEWSLETTER

November 16, 1979

FRIDAY MORNING SOCIAL GROUP NEWSLETTER---FOR MEMBERS AND THEIR FAMILIES

Calender Announcements: Friday, November 23--The group will not meet because of the Thanksgiving Holiday. Fridays, November 30, December 7, and December 14--regular meetings of our group. Friday, December 21--A Holiday Party--Families will be invited toward the end of the morning session. More information about the Holiday Party will come in the next Newsletter.

The Leaders of the Friday Morning Social Group:
Bea Wooley, a peer counselor, has had many years of experience as a special education teacher.
Chris Aasved, a graduate student nurse.
Enid Galler, a former elementary school teacher earning a Certificate in Gerontology.
Sonny Morse, a volunteer, who leads exercises and singing.

News about Our Members: Olive Wiggle is away visiting her daughter in Indiana. She will spend Thanksgiving there and will be back to our group on November 30.
Evie Galbraith will tour the Christmas Display in Frankenmuth, Michigan with a Senior Citizen's Group this week. She will be back with us on Nov. 30th, also.
Mary Owiesny comes to our group from the farthest distance, Detroit.

Some of our Weekly Activities: Exercises to music--it is fun, and we know it is good to get that blood circulating. Fred Bock especially enjoyed the swimming movements we made with our arms.
Memory Skills Lesson--Last week we played the game "I Packed My Trunk for Klondike." Ed Miller packed a hippopotamus in the trunk, while Harold Olsentook along a baseball bat!
Painting--Joe Mar tinez painted a beautiful scene of a meadow, stream, and mountatins. Joe was surprised at his skill with the paint brush, because he said he had not painted since he was a child.

HAVE A LOVELY THANKSGIVING. TILL WE MEET AGAIN ON NOVEMBER 30.

SAMPLE GROUP SCHEDULE

NEWCOMERS GROUP

March 14, Wednesday

Discussion of Dinner at Lurie Terrace
Discussion of ending of group
Break
Guests to speak about their involvements in various senior citizen's groups

Axelina Van Zaanen
Resident of Lurie Terrace, R.S.V.P. Volunteer, active in the Senior Citizen's Guild

Claire Grew
Art at Senior Citizen's Guild
Teaches with the Literacy Council
Resident of Lurie Terrace

Dorothy Peters
Burns Park Recreation
Catholic Senior Services
Ann Arbor Parks and Recreation

Questions and discussion

MARCH 19, Monday

We will be going to the Salvation Army Day, which happens every Monday.
This week:

10:00	Fellowship Time - Midmorning Snack
10:00 - 11:30	Furniture Refinishing with Ron Kaufman Crafts with Averil Mattson
10:30-12:30	Oil Painting with Molly McGee
NOON	Lunch Served donation $1.50
1:00-2:00	Service Project with Audrey Hodges
	Talent Show! Bring your musical instrument, REading, Poem or skit.

There is also a gym, Millie can give us more info since she and Dorothy have been there.

If you call they will pick you up at home, they will be picking all of us up at Turner.

THURSDAY, MARCH 29 OUR LAST DAY

POT LUCK, EVERYONE BRING SOMETHING

Also, bring something you would like to share with the group, music, poetry, a personal possession that is very special to you, something you have made,etc.

ORGANIZING WRITING GROUPS

TURNER GERIATRIC CLINIC

WRITING GROUP

Po Chui, Collected Works, XXVIII (on the birth of a son in his old age)

I THINK UPON IT IN QUIET. THERE IS AMPLE CAUSE FOR JOY AND AMPLE CAUSE FOR LAMENTING.

I. WHY A WRITING GROUP?

1. Creativity
2. To get a better understanding of one's own life
3. To preserve and pass on memories
4. To share one's experiences with others
5. To interpret what has happened and reflect on its meaning as time passes.

II. WHY A GROUP?

1. To support and encourage us as we write.
2. To provide feedback...to hear how one's writing affects others.
3. To share with others and to learn from them.

Ruth Campbell
Turner Geriatric Clinic
764-6831

TURNER GERIATRIC CLINIC WRITING GROUP

HOW IT STARTED

A brief notice was placed in the Senior Reporter stating that a group was being formed of people who wanted to write a book or short stories about their own lives. After twelve people called, the group was started. The first meeting was on March 20, 1978. There are now fifteen members, ranging in age from the early sixties to ninety. The group meets two hours weekly in the Clinic.

FORMAT

Before the first meeting, the group leader sent out a letter asking people to bring something they had written and would like to read to the group. At the meeting the group leader introduced herself and then each member introduced himself/herself, briefly giving reasons for wanting to join a writing group. The group leader gave what she saw as the purpose of the group, adding that it was up to them to decide what they wanted the group to be and what they needed from the group leader.

The purpose of the group was to:

1. Encourage and support each other in writing autobiographical material.
2. Help each person write what he/she wanted in a natural way.

Goals of individual members included the following.

1. To pass on what they had experienced in their lives to their children and grandchildren so it would not be forgotten.

2. To get something published.

3. To have a chance to write in various forms and get some feedback from the group members and the group leader.

From the first meeting a pattern was established of each person reading for 3 to 5 minutes, after which the group would make comments. At the request of the members, the leader made weekly assignments which could be disregarded if anyone preferred to do something else but which provided a structure that most of the members found comfortable.

The assignments were (in more or less the order given):

1) Write something around the phrase, "When my parents were young..."
2) Bring in a picture of yourself as a child and describe what you remember about the time the picture was taken.
3) Bring in a picture of yourself as an older child and do the same.
4) Write about a situation in your life in which one strong emotion is present--let the class discuss what emotion is intended.
5) Write about the teens with the word "awakening" in mind.
6) Write about a situation in your late or early teens in which there was a conflict.
7) Write four lines on "My life's ambition."
8) Write anything you want.

There were other assignments but basically a chronological order was kept with specific assignments given to get the students to do something they needed practice in--such as revealing emotion, writing about conflict as well as pleasant memories.

General Suggestions:

1. Find out what the level of ability in your group is and go along with it. If people cannot write use a tape recorder but

then write some kind of summary of what is on each tape so people can go back and listen to specific sessions.

2. It is best if people are at about the same level in writing ability. This does not mean flawless grammar or spelling but just the ability to put together sentences in a certain way. I think this kind of group can be done at any level but it is difficult if some people are clearly much more advanced than others. Widely ranging educational backgrounds, life styles, regional backgrounds are however, an advantage in providing a stimulating atmosphere.

3. Don't make too many rules. Some structure is good such as using assignments and having everyone (or as many as possible) read each week, but be open to individual needs and group suggestions. Assignments in this group were made at the end of each session and were rarely determined in advance.

4. Model a group norm of support for each member's efforts. It takes a while for group members to feel comfortable about negative criticism but it comes after a feeling of trust is established.

5. Encourage discussion on memories evoked in others by one student's writings. The members stimulate each other and awaken memories once thought forgotten.

6. Allow some time for informal chats--a break in the session for coffee, for example.

7. People get to know each other by listening to personal writing. If someone does not want to read something make it clear they can give it to the leader privately for criticism. Encourage group interaction by continually asking members for their opinions and feelings about what has been read.

8. Take the writing seriously but encourage humor and a sense of fun, as well as excitement in the group. Writers of all ages thrive on lavish praise spiced with <u>some</u> criticism.

PARTICIPANTS' SHORT EVALUATION FORM--SAMPLE NO. 1

Nursing Home Resident Opinions and Suggestions

1. What do you remember about the talk on _____?

2. What was helpful to you about the talk?

3. What did you like?

( ) speaker
( ) friendly atmosphere
( ) seeing people
( ) getting out
( ) asking questions
( ) learning something new

4. If there were pictures, slides, handouts, demonstrations, or things to pass around, did you like them? Would you like to have any of the things shown for your own use?

5. Was there anything you would like changed for the next time?

6. What other topics would you like to hear about?

7. Other comments?

PARTICIPANTS' SHORT EVALUATION FORM--SAMPLE NO. 2

TURNER/SALINE PROGRAM EVALUATION

NAME_____ JUNE 18, 1980

ADDRESS_____ DON'T FORGET TO REMEMBER

PHONE_____

IN ORDER TO MAKE THE PROGRAMS AS USEFUL AS POSSIBLE, WE WOULD LIKE YOUR COMMENTS. WE RELY ON THEM TO MAKE CHANGES WHICH WILL IMPROVE FUTURE PROGRAMS. THANK YOU.

1. THE PROGRAM GAVE ME NEW INFORMATION. AGREE DISAGREE
2. THE INFORMATION WAS PRACTICAL TO ME. AGREE DISAGREE
3. I WILL USE ONE OF THE SUGGESTIONS MADE TO IMPROVE MY MEMORY. AGREE DISAGREE
4. THE DISCUSSION RELIEVED SOME OF MY ANXIETY ABOUT MEMORY CHANGES. AGREE DISAGREE
5. I ENJOYED BEING WITH PEOPLE OF MY AGE AGREE DISAGREE
6. HOW DID YOU LEARN ABOUT THE PROGRAM? CHECK AS MANY AS APPLY.

   ( ) FAMILY ( ) DOCTOR

   ( ) FRIEND ( ) NEWSPAPER, WHICH ONE?_____

   ( ) SALINE HOSPITAL ( ) FLYER ( ) OTHER_____
7. WOULD YOU LIKE MORE INFORMATION ON THIS SUBJECT? YES NO
8. HOW CAN WE IMPROVE THESE PROGRAMS?

TO HELP US PLAN FOR THE FALL PROGRAMS, PLEASE CHECK OFF THE TOPICS WHICH INTEREST YOU.

_____DIABETES
_____STRESS
_____HOUSING
_____PREPARING FOR NURSING HOMES
_____BLADDER & PROSTATE
_____MEDICARE & SOCIAL SECURITY
_____HEALTH EMERGENCIES
_____RELATIONSHIPS BETWEEN THE GENERATIONS
_____DEPRESSION
_____MONEY MANAGEMENT, WILLS, GUARDIANSHIP
_____EYES AND EARS
_____LIVING ALONE
_____SLEEP
_____COPING WITH PAIN
_____DENTAL/PERIDONAL CARE
_____SAFETY & SECURITY AT HOME

TELEPHONE INTERVIEW OF WORKSHOP PARTICIPANT

1. Can you name at least three things that you liked about the workshop?

( ) speakers
( ) friendly atmosphere
( ) seeing people
( ) handouts
( ) other:

2. Did you pick up handouts? ( ) yes ( ) no

If so, how did you use them?

3. What information given at the workshop did you find most helpful?

3. In what ways did you use the information?

( ) practiced techniques suggested by speakers
( ) relieved anxiety
( ) caused me to change a previous habit (routine, method)
( ) caused me to seek more information
( ) answered questions I'd been thinking about
( ) gave me info I will be able to use in the future
( ) other:

5. How often do you use this information?

( ) very often, frequently
( ) two or more times
( ) once
( ) haven't, but plan to
( ) do not use info

6. Did you share the information that you learned at the workshop with others? ( ) yes ( ) no

If so, with whom?

( ) wife
( ) husband
( ) son
( ) daughter
( ) grandchildren
( ) friends
( ) relatives
( ) other:

7. Describe the types and numbers of community agencies in this area that you know provide services for senior citizens. (Can you name three?)

( ) Salvation Army
( ) R.S.V.P.
( ) Turner Clinic
( ) Senior Citizens Guild
( ) Washtenaw Co. Council on Aging
( ) other(s):

8. Do you use any of these services? ( ) Yes ( ) No

Which ones:

How often?

( ) once a week
( ) twice a month
( ) monthly
( ) other:
( ) less than 3 times a year
( ) once a year
( ) not sure

If not, why not?

( ) too busy, no time
( ) too tired
( ) physically unable
( ) doesn't offer the service I need
( ) have used it once, not helpful
( ) other:

9. Did you learn about a new resource as a result of the workshop? ( ) Yes ( ) No

If so, which one?

10. Have you used it or do you plan to use it? ( ) Yes ( ) No

11. Have you told someone else about it? ( ) Yes ( ) No

12. Did you see people you knew at the workshop? ( ) Yes ( ) No

13. Did you meet someone new? ( ) Yes ( ) No

14. Did you talk with other people at the workshop?
( ) Yes ( ) No

If so, whom? ( ) peer counselor
( ) speaker
( ) participants

15. How did you hear about the workshop?

( )	from family	( )	newspaper
( )	friend	( )	advertising posters
( )	Turner Clinic	( )	mail flyers
( )	doctor	( )	other:

16. Would you come to another workshop? ( ) Yes ( ) No

PUBLICITY GUIDELINES

by Barbara Sattinger, Peer Counselor

Effective publicity must reach the population interested in the information to be presented, using all available media. The programs Turner presents to the Senior population in Ann Arbor and neighboring communities are announced by these methods: 24 church bulletins; four local radio stations; 4 weekly newspapers in nearby towns as well as 2 daily newspapers, the Ann Arbor News and the Ypsilanti Press; and in newsletters published by five area agencies.

Because churches and radio stations have various deadlines, it is best to mail announcements to them one month in advance. The weekly newspapers, "Dexter Leader," "Milan Booster," "Chelsea Standard," and "Manchester Enterprises" all have the same deadline. The dailies need publicity material one to two weeks in advance.

The radio stations contacted are WAAM, WPAG, WUOM, and WEMU. These stations present public service announcements once or twice daily.

Newsletters of service agencies are the most varied in their deadlines, and at times publish irregularly. It is important to treat these individually, as they are read by a large segment of the senior population. These publications are the "Senior Reporter," of WCCOA, "Golden Nuggets," of the Ann Arbor Recreation Department, "RSVP News," and "Open Lines," also published by WCCOA. Other newsletters and monthly newspapers published locally which are good to contact are "Washtenaw Jewish News," "The Alchemist," "Senior Citizens' Guild Newsletter," "Aging in Michigan," a publication of services to the aging, and the "Ann Arbor Adviser."

SAMPLE PRESS RELEASE

For Immediate Release
Contact Claudia Kraus

On Thursday, March 15th from 1:00 to 3:30 p.m., the Turner Geriatric Clinic will offer a workshop on "Sleep: Too Little or Too Much." Experts in this field will talk on changing sleep patterns as people grow older and the effects of sleep medications and their possible dangers. Various methods of coping with interrupted sleep will be examined.

Among the speakers will be Dr. Wiecher Van Houten of the University of Michigan Department of Psychiatry. A representative from the Henry Ford Hospital Sleep Research Center also will address the workshop.

There will be ample time to ask questions. Senior Citizens are invited to attend and participate. There is no admission fee but please call if you plan to attend, 764-6831.

Sample Small
Group Announcement

MEMORY GROUP

The Turner Clinic is pleased to announce its schedule of speakers for the upcoming Memory Worshop. Each week there will be a different speaker with a special knowledge of memory and how various influences affect it. There will be time after each presentation for questions from the audience. The second hour of each class will be devoted to problem solving techniques and exercises to improve the memory.

SCHEDULE OF SPEAKERS

1. March 25th - Normal Changes of Memory with Aging- Professor Howard McCluskey
2. April 1st - How Drugs Can Affect Memory- Julie Reynolds, Pharmacist
3. April 8th - Diseases That Affect Memory- Dr. Wolfgang May
4. April 15th - Nutrition As It Affects Memory- Dr. Edward Domino
5. April 22nd - Current Research on Memory- Dr. Aaron Smith
6. April 29th - Affects of Depression, Stress, and Loss on Memory- Dr. Gail Barton
7. May 6th - Panel of Individuals Who Use Their Memory Professionally

The Memory Group will meet every Tuesday for seven weeks from 10 a.m. to noon. There is no fee for attending the classes.

SAMPLE PROGRAM SCHEDULE FOR MAILINGS

ACTIVITIES LISTING

FAMILY GROUP - Designed to assist family members with speakers and discussion to make decisions concerning aging spouses, parents or siblings. Meetings every ot er Tuesday evening, 6:30-8 p.m. For information call Marilou Aportadera or Dodie Browning at 764-6831.

EXERCISE TO MUSIC - Phyllis Weikart of the University of Michigan Physical Education Department leads exercise geared to the needs of the elderly. Wear loose clothes. Meets every Friday 10:30- noon.

LOW VISION SUPPORT GROUP - Speakers and exchange of ideas concerning ways to adapt to vision loss. Meets monthly. Next meeting scheduled for Wed. February 27th, 1-3 p.m. Call Enid Galler at 764-6831.

LOW VISION CLASSES - Taught by the Greater Detroit Society for the Blind. The class teaches practical daily skills to the low visioned. Meetings twice a month. Wednesdays from 1-3 p.m. February meetings on the 6th and 20th. Call Enid Galler at 764-6831.

BRIDGING THE GENERATION GAP - Designed for families or individual family members concerned with establishing better family relationships. 6 sessions every other Tuesday evening, 6:30-8 p.m. Beginning February 5th. For information call Dodie Browning at 764-6831.

FRIDAY MORNING GROUP - A group for the confused elderly. Activities designed to increase orientation and social interaction. Meets Every Friday, 9:30-12:30. Preliminary interview required. Fee $5 for supplies. Call Enid Galler at 764- 831.

FROM GENERATION TO GENERATION: Women Of All Ages - Discussions and sharing across the generations on topics such as beauty, aging,close relationships and transitions. 8 sessions, Thursdays 10 a.m. to noon, starting February 7th. Call Claudia Kraus or Barbara Chenoweth at 764-6831.

BOOK LOVERS CLUB - Review and exchange and discuss books. Meetings once a month. call Dorothy Ouradnik or Verna Barton at 764-6831.

HEARING GROUP I - Audiologists from the U of M Speech and Hearing Clinic will conduct a series of classes designed to help people improve their ability to communicate. Topics covered will include hearing aids, diagnoses and treatment. In the second hour of each meeting lip reading instruction will be given in small groups. Each group member will receive a free hearing screening. 6 weekly sessions starting Tuesday, February 19th from 1-3 p.m. Call Lucinda Stevens at 764-6831.

HEARING GROUP II - May Booth of Tri-County Deaf Senior Citizens will discuss resources available to the hard of hearing and ways to adapt to hearing loss, including sign language. Meetings on the second Tuesday of each month from 1-3 p.m. Call Lucinda Stevens at 764-6831.

WRITING GROUPS - Older people write and share their writing with others in a small weekly group. Monday group, 1-3 p.m. call Ruth Campbell or Tuesday group, 1-3 p.m. call Claudia Kraus at 764-6831.

MEMORY GROUP - Information and discussion about the myths and facts of memory changes in aging. Topics to be addressed include, what is senility; is memory loss inevitable; does nutrition affect memory; do drugs affect memory; does depression affect memory. To begin in March, 6 sessions. Fee $15. Call Lucinda Stevens at 764-6831.

RELAXATION TECHNIQUE - Phyllis Green of the Wholistic Health Council will teach relaxation technique for managing stress. Limit 10 people. To begin in late March. 6 sessions, fee $15. Call Claudia Kraus.

PEER COUNSELLOR PROGRAM - Older adults available for individual counselling, specifically to help others manage changes that accompany aging. Peer Counsellors can be reached at 764-6831.

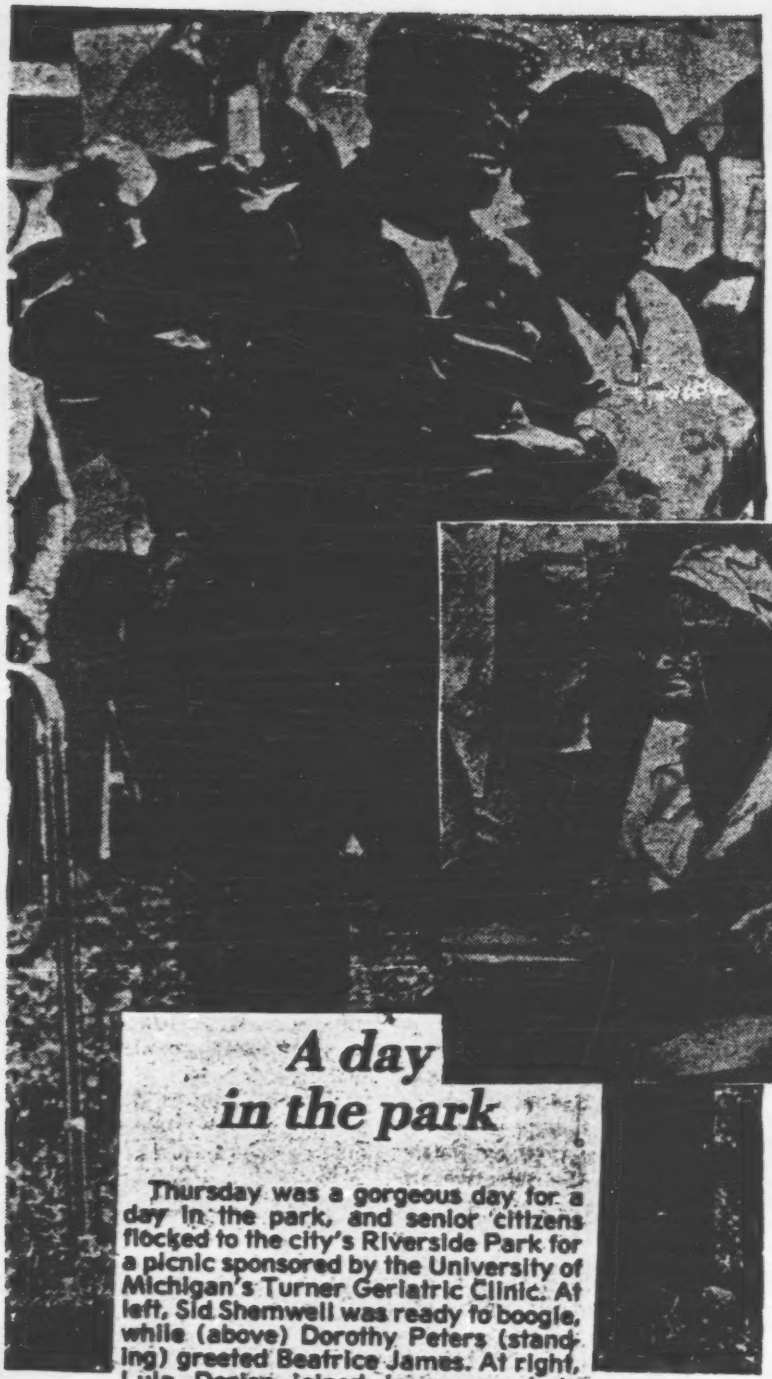
HEALTH EDUCATION WORKSHOPS

- MAKING IT ALONE: Now or Later
  Thursday, February 21st, 1-3:30 P.M.
- SECURITY AND SAFETY IN YOUR HOME AND ON THE STREET
  Thursday, March 20, 1-3:30 P.M.
- TAKING CARE OF YOUR EYES AND EARS
  Thursday, April 17, 1-3:30 P.M.
- NUTRITION AND SPECIAL DIETS
  Thursday, May 15, 1-3:30 P.M.
- MEMORY LOSS AND DEPRESSION
  Thursday, June 16, 1-3:30 P.M.

Monthly Health Education Workshops are also being held in Ypsilanti at the Willow Run Nutrition Site on the last Friday of each month from 12:30 - 2 P.M. For more information call Ruth Campbell at 764-6831.

Workshops are also being held at the Saline Community Hospital once a month. For more information call Barbara Chenoweth at 764-6831 or Judy Cook at 429-5435.

SAMPLE NEWSPAPER ARTICLES



A day in the park

Thursday was a gorgeous day for a day in the park, and senior citizens flocked to the city's Riverside Park for a picnic sponsored by the University of Michigan's Turner Geriatric Clinic. At left, Sid Shemwell was ready to boogie, while (above) Dorothy Peters (standing) greeted Beatrice James. At right, Lula Dozier joined in a parachute game, bouncing balls on a sheet. (Staff photos by Jack Stubbs)

Sight-impaired elderly offered help

The University of Michigan's Turner Geriatric Clinic is sponsoring a series of classes for legally blind and low-visioned older people, conducted by the Detroit Society for the Blind, to teach skills which promote independent living.

The new class will be held every other week, in two-hour sessions, for six to nine months.

cs will include communica-cills, activities of daily liv-wing, handling of coins and cy, continuing use of hand-ng, low-vision aides,

Elderhostels

Editor, The News:

We were happy to see Bob Walton's article in Sunday's Ann Arbor News concerning the Elderhostels. Last summer we attended one of them, and we are already enrolled for another for the coming summer.

Your eligible readers (i.e. those over 60) may be interested to know that the Turner Clinic is having an open meeting concerning the Elderhostel program at the Clinic, 1010 Wall Street, Friday noon, April 11.

A "Brown Bag" luncheon meeting is open to anyone interested, and will provide a lot of good information.

The Elderhostel we attended was very stimulating and enjoyable, and we are looking forward eagerly to this summer's experience.

Dorothy and Alexander Miller, Whitmore Lake

Sample Workshop Announcements

TURNER LEARNING PROGRAMS

Turner Geriatric Clinic
1010 Wall Street
Ann Arbor, Michigan 48109
(313) 764-6831

PRESENTING THE FIRST FALL WORKSHOP

"H E A D A N D T O E"

SKIN AND HAIR: WHAT ARE THE CHANGES AS WE GROW OLDER?
WHAT CAN WE DO ABOUT THEM?

Dr. Cara G. Doane, Dermatologist

DOES THE SHOE FIT? TRICKS OF THE TRADE

BANCROFT BRIEN, FORMER OWNER OF BRIEN-PETERSON SHOES, INC.

FEET: CARE AND PROTECTION

Dr. Charles R. Rettig, Podiatrist

DATE: THURSDAY, SEPTEMBER 20

TIME: 1:30 to 4:00 p.m.

PLACE: Turner Geriatric Clinic
1010 Wall St.

NO ADMISSION FEE

PLEASE CALL 764-6831 IF YOU NEED TRANSPORTATION

TURNER LEAI PROGRAM

TURNER GERIATRIC CLINIC

1010 WALL STREET
ANN ARBOR, MI
48109

MONEY MANAGEMENT

FOR PEACE OF MIND

THURSDAY, APRIL 17TH

1-3:30 P.M.

SPEAKERS .....

"ESTATE PLANNING AND WILLS" ..... SUSAN WESTERMAN

LAW PARTNER, DOBSON, GRIFFIN AND WESTERMAN

"MAKING CHOICES IN THE MARKET PLACE" ..... MARION PRINCE

WASHTENAW CTY. COOPERATIV EXTENSION SERVICE

"CONVERTING GOLD, SILVER AND COINS INTO CASH" ..... BRIAN GODWIN

ANN ARBOR STAMPS AND COINS

TURNER LEARNING PROGRAMS ARE FREE TO THE PUBLIC. FOR MORE INFORMATION CALL 764-6831.

TURNER GERIATRIC CLINIC
1010 WALL STREET
ANN ARBOR, MI 48109
764-6831

NUTRITION SHAKEDOWN

THURSDAY, MAY 15
1 - 3:30 P.M.

PANEL DISCUSSION

ANNE SHRYOCK, NUTRITIONIST, U OF M SCHOOL OF NURSING

"FATS AND THE HEALTHY HEART"

MARJORIE MURPHY, NUTRITIONIST, U OF M SCHOOL OF NURSING

"DO I NEED TO TAKE VITAMINS"

MARION PRINCE, R.D., EXTENSION HOME ECONOMIST

" SHAKEDOWN ON SALT"

INTERMISSION (2:15)

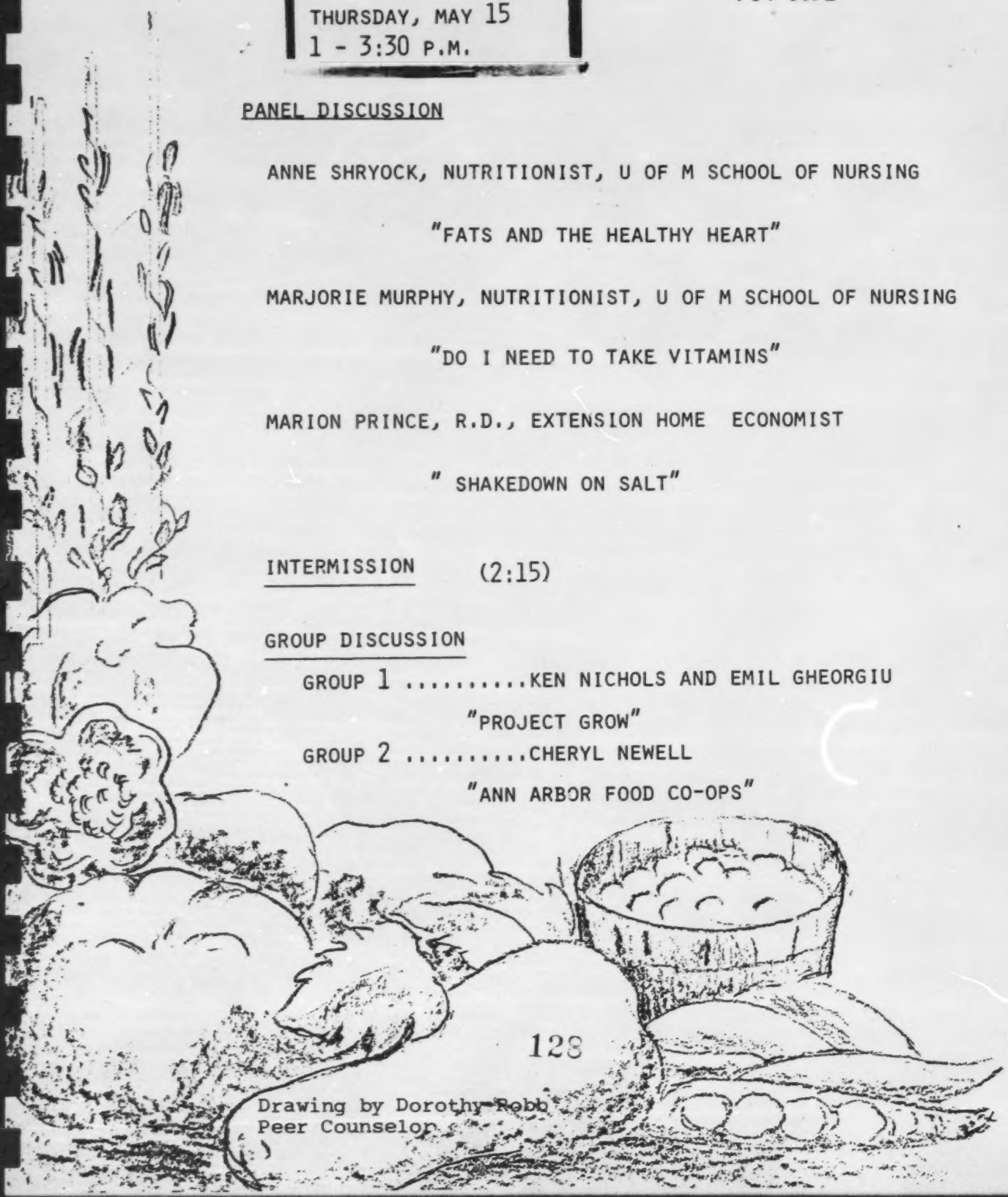
GROUP DISCUSSION

GROUP 1 .....KEN NICHOLS AND EMIL GHEORGIU

"PROJECT GROW"

GROUP 2 .....CHERYL NEWELL

"ANN ARBOR FOOD CO-OPS"



Drawing by Dorothy Robb
Peer Counselor

ALL AGES WELCOME AT THE NEXT WORKSHOP AT THE TURNER GERIATRIC CLINIC ***

Y O U N G E R T H A N S P R I N G T I M E

DATE: Thursday, May 17

TIME: 1:00 - 3:30 p.m.

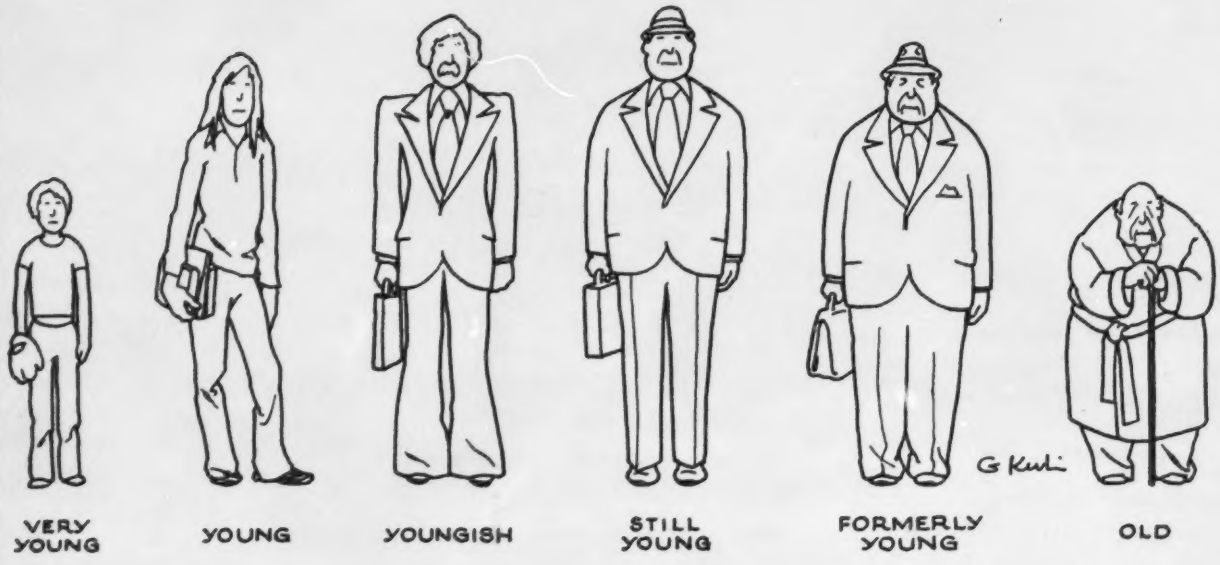
PLACE: Turner Geriatric Clinic
1010 Wall Street Ann Arbor

764-6831

Men!
Women!

PRESENTING: CARREN SANDALL, Fashion Columnist Ann Arbor News

Bring something you love to wear that is somewhat out of date--she will show you how to put it back in fashion.



WHAT IS YOUNG? WHAT IS OLD? JOIN US FOR A LIVELY DISCUSSION AFTER THE FASHION PRESENTATION. THIS WORKSHOP IS FREE OF CHARGE.

As Your Children Grow Older ...

relationships between adult children and their parents

1:00 – 3:30

THURSDAY JUNE 21st.

FREE!!!

TURNER GERIATRIC CLINIC

— 1010 WALL ST. —

764-6831

124

- eva blocker

TURNER HEALTH FAIR

Saturday, June 14

10am-3pm

SPONSORED BY WASHTENAW COUNTY COUNCIL
ON AGING AND TURNER GERIATRIC CLINIC
1010 WALL STREET
ANN ARBOR, MI

NUTRITION CONSULTATION-
MARJORIE MURPHY

A PHARMACIST- BRING YOUR DRUGS & ASK QUESTIONS

BIOFEEDBACK- DEMONSTRATION BY PAT BLACKMER

HEALTH SCREENING-
- ANEMIA
- PODIATRY
- BLOOD PRESSURE
- DENTAL
- VISION
- HEARING
- DIABETES

FILMS-
- "ONE MORE WINTER"
- "SEXUALITY"
- "PHYSICAL/SENSORY CHANGES OF AGING"
- "ARTHRITIS"
- AND MORE

132

TRANSPORTATION:
CALL IF YOU NEED IT, 764-6831

*DRAWING BY REGINAL NUNN

- AND MUCH MORE ...
- ALL FREE
- JOIN THE FUN
- BRING YOUR FRIENDS
- FREE PARKING

BOOTHS-
- KIWANIS GOLDEN AGE CARD
- ARTHRITIS ASSOCIATION
- AMERICAN CANCER SOCIETY
- SOCIAL SECURITY
- SENIOR LAW PROGRAM
- MEDICARE
- ANN ARBOR "Y"
- ANN ARBOR HOUSING COMMISSION
- PARKWAY MEADOWS - LOW INCOME HOUSING
- MICHIGAN HEART ASSOC.
- U HOSPITAL OCCUPATIONAL THERAPY
- ANN ARBOR CENTER FOR INDEPENDENT LIVING
- FOOD STAMPS
- HOMEMAKER SERVICES
- CHILD & FAMILY SERVICES

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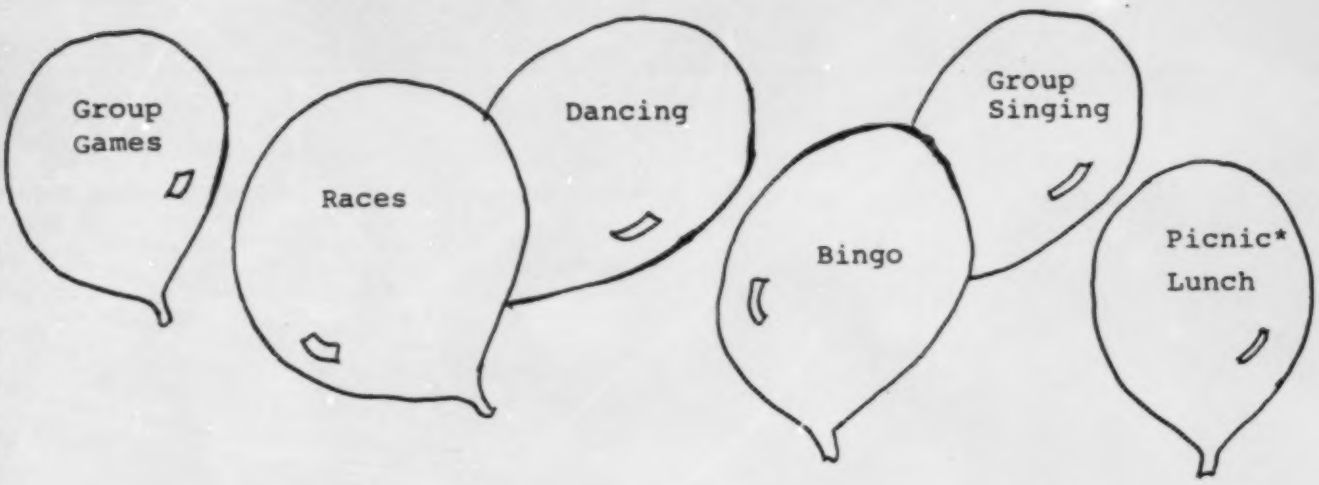
TURNER CLINIC INVITES YOU TO:

A DAY IN THE PARK



WHEN: THURSDAY, JULY 17 (Rain Date, July 24th)

WHERE: RIVERSIDE PARK -- RIGHT BEHIND TURNER CLINIC

TIME: 10:30 to 2:00 p.m.

*IMPORTANT: ANYONE OVER 60 MAY RECEIVE A FREE BOX LUNCH OFFERED BY CSA NUTRITION PROGRAM

Beef and Cheese Sandwich
Italian Cole Slaw - Tropical Fruit Cup
Assorted Relishes - Brownie
Milk

OTHER AGES WILL BE CHARGED $1.60

IF YOU WOULD LIKE A BOX LUNCH, PLEASE CALL TURNER CLINIC, 764-6831, BY MONDAY, JULY 7th

Free Parking Available at: TURNER CLINIC LOT
RIVERSIDE PARK LOT
BROADWAY KROGERS LOT

TRANSPORTATION AVAILABLE: CALL TURNER CLINIC 764-6831

ALSO: A ROOM WILL BE AVAILABLE FOR THOSE WHO WOULD LIKE TO COME INSIDE TO REST.

TURNER GERIATRIC CLINIC & SALINE COMMUNITY HOSPITAL

PRESENT:

"TAKING CARE OF YOUR HEART"

A PROGRAM FOR SENIOR CITIZENS

"WHAT YOU SHOULD KNOW ABOUT HEART DISEASE" ...Dr. Timothy Byrnes, Internal Medicine, Saline Hospital

"WAYS TO TAKE CARE OF YOUR HEART".....A Panel Discussion of Diet, Exercise & Stress

PLACE: SALINE COMMUNITY HOSPITAL
400 W. RUSSELL, BLUE ROOM

DATE: WEDNESDAY, APRIL 9

TIME: 11 a.m. - 1 p.m.

LUNCH: TO RESERVE A LUNCH, REGISTER AND BUY A MEAL TICKET AT 10:45 a.m. SPACE LIMITED; FIRST COME, FIRST SERVE.

TRANSPORTATION: CALL

-IN MANCHESTER:
OTTO TIMMERMAN, 428-8190

-IN SALINE:
SENIOR CENTER, 429-9274

THIS PROGRAM HAS BEEN PLANNED BY SENIOR CITIZENS FROM THE SALINE-MANCHESTER AREAS AS PART OF THE TURNER LEARNING PROGRAMS, SPONSORED BY THE TURNER GERIATRIC CLINIC OF THE UNIVERSITY OF MICHIGAN.

SPECIAL THANKS FOR THE COOPERATION & SUPPORT OF: SALINE AREA SENIOR COUNCIL, INC., SALINE AREA COMMUNITY SCHOOLS, SALINE EVANGELICAL HOME, MANCHESTER AREA SENIOR CITIZENS, MANCHESTER COMMUNITY EDUCATION, MILAN AREA SENIOR CITIZENS, MILAN PARKS AND RECREATION AND MILAN SENIOR COUNCIL.

DRAWING BY REGINALD NUNN, SALINE EVANGELICAL HOME

TURNER GERIATRIC CLINIC & SALINE COMMUNITY HOSPITAL

PRESENT:

"LIVING WITH ARTHRITIS"

A PROGRAM FOR SENIOR CITIZENS

"ARTHRITIS: AN OVERVIEW".....DR. IVAN DUFF, ARTHRITIS SPECIALIST, TURNER GERIATRIC CLINIC

"ARTHRITIS: A WAY OF LIFE".....FLORENCE TILLMAN, R.N., GERIATRIC CLINICAN, TURNER CLINIC

PLACE: SALINE COMMUNITY HOSPITAL
400 W. RUSSELL, BLUE ROOM

DATE: WEDNESDAY, APRIL 30

TIME: 11 A.M. TO 1 P.M.

LUNCH: TO RESERVE A LUNCH, REGISTER AND BUY A MEAL TICKET AT 10:45 A.M. SPACE LIMITED; FIRST COME, FIRST SERVE.

TRANSPORTATION: CALL

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DRAWING BY REGINALD NUNN, SALINE EVANGELICAL HOME

TURNER GERIATRIC CLINIC & SALINE COMMUNITY HOSPITAL

PRESENT:

"DON'T DEFEAT YOUR FEET"

A PROGRAM FOR SENIOR CITIZENS

11:00-11:50 "TAKING CARE OF YOUR FEET".....DR. ANTHONY BUTO, PODIATRIST

BREAK

12:00-12:30 "DOES THE SHOE FIT? TRICKS OF THE TRADE"..... BANCROFT BRIEN, FORMER OWNER BRIEN-PETERSON SHOES

12:30-1:00 "TIPS FOR CORRECT WALKING".....DOROTHY MILLER, FORMER PHYSICAL EDUCATION TEACHER, U. OF M.

PLACE: SALINE COMMUNITY HOSPITAL
400 W. RUSSELL, BLUE ROOM

DATE: WEDNESDAY, MAY 21
11 A.M. - 1 P.M.

LUNCH: TO RESERVE LUNCH, REGISTER AND BUY MEAL TICKET AT 10:45 A.M.

TRANSPORTATION: CALL

-IN MANCHESTER,
OTTO TIMMERMAN, 428-8190

-IN SALINE,
SENIOR CENTER, 429-9274

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DRAWING BY REGINALD NUNN, SALINE EVANGELICAL HOME

TURNER GERIATRIC CLINIC & SALINE COMMUNITY HOSPITAL

PRESENT:

"DON'T FORGET TO REMEMBER"

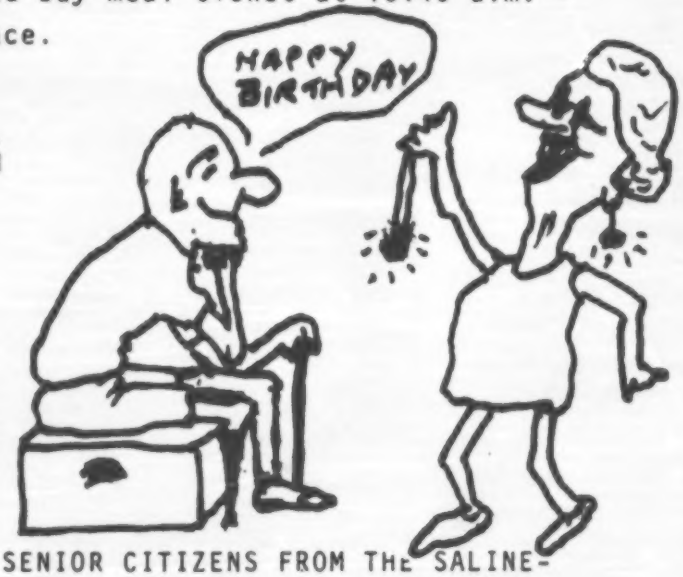
a program for Senior Citizens

11:00-12 "Making the Most of Your Memory".....Dr. Charles Reeder, University of Michigan/Saline Hospital

12:00-12:10 BREAK

12:00-1 "Memory Improvement Exercises".....Bea Wooley, retired Special Education Teacher, Turner Clinic Peer Counsellor.

1:00 p.m. Lunch: register and buy meal ticket at 10:45 a.m. - limited space.



PLACE: SALINE COMMUNITY HOSPITAL
400 W. RUSSELL, BLUE ROOM

DATE: JUNE 18, WEDNESDAY

TIME: 11 a.m. - 1 p.m.

TRANSPORTATION: CALL

_in MANCHESTER:
OTTO TIMMERMAN, 428-8190

_in SALINE:
SENIOR CENTER, 429-9274

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DRAWING BY REGINALD NUNN, SALINE EVANGELICAL HOME

TURNER LEARNING PROGRAMS

TAKING CARE OF THE HEART

WORKSHOP

FRIDAY, JANUARY 25, 1980

12:30 - 2 P.M.

WILLOW RUN NUTRITION SITE
GILES BLDG. 134 SPENCERLANE
YPSILANTI

OUR SPEAKER,

DR. JEFFREY ANDERSON, HEART SPECIALIST
UNIVERSITY HOSPITAL

WILL WELCOME 'HEARTY' QUESTIONS
NO ADMISSION FEE

WANT LUNCH? NEED TRANSPORTATION?

CALL 483-8797

HAVE
A HEALTHY HEART

HAVE
A HAPPY HEART

TURNER LEARNING PROGRAMS

EYES AND EARS WORKSHOP

FRIDAY, MAY 23, 1980

12:30 - 2 P.M.

WILLOW RUN NUTRITION SITE
134 SPENCER LANE
YPSILANTI

SPEAKERS: DR. RALPH RUPP, "EARS"
UNIVERSITY OF MICHIGAN SPEECH AND HEARING CLINIC
764-8444

DR. JEROME EPSTEIN, OPTHAMOLOGIST "EYES"
482-6897

THERE WILL BE TIME FOR QUESTIONS TO BOTH SPEAKERS

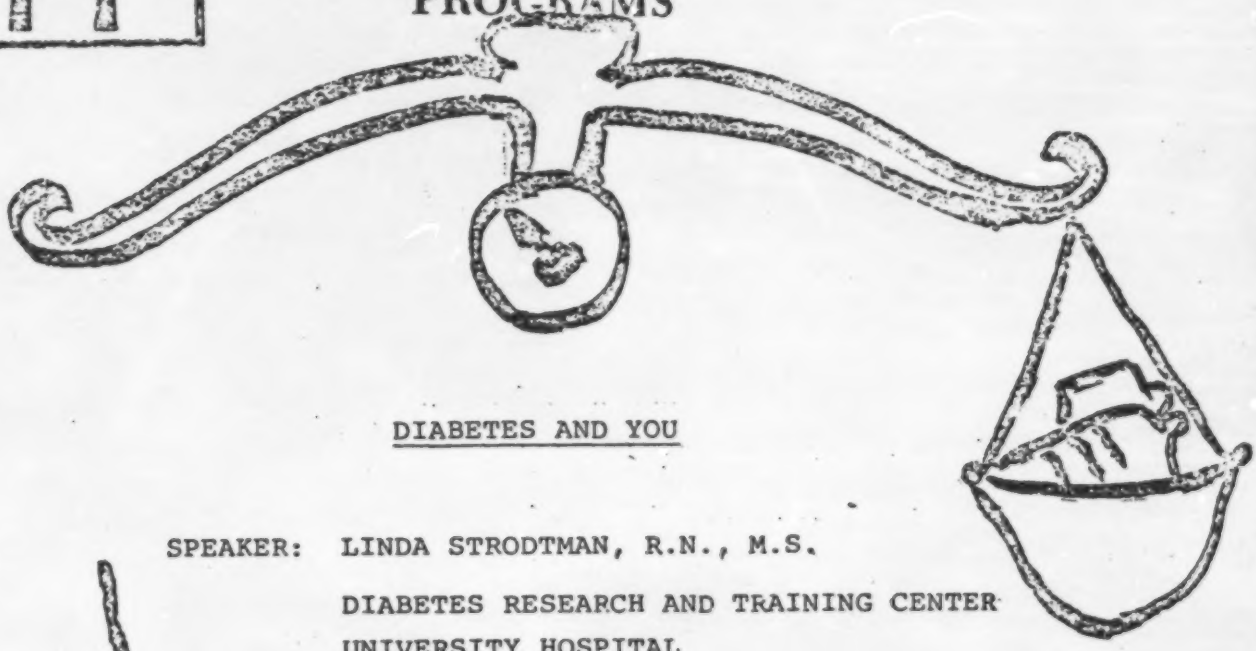
NO ADMISSION FEE

WANT LUNCH? NEED TRANSPORTATION?

CALL 483-8797 SOON

SPONSORED BY: TURNER GERIATRIC CLINIC, UNIVERSITY HOSPITAL
WASHTENAW COUNTY SENIOR NUTRITION PROGRAM
FUNDED BY THE ADMINISTRATION ON AGING

TURNER LEARNING PROGRAMS



DIABETES AND YOU

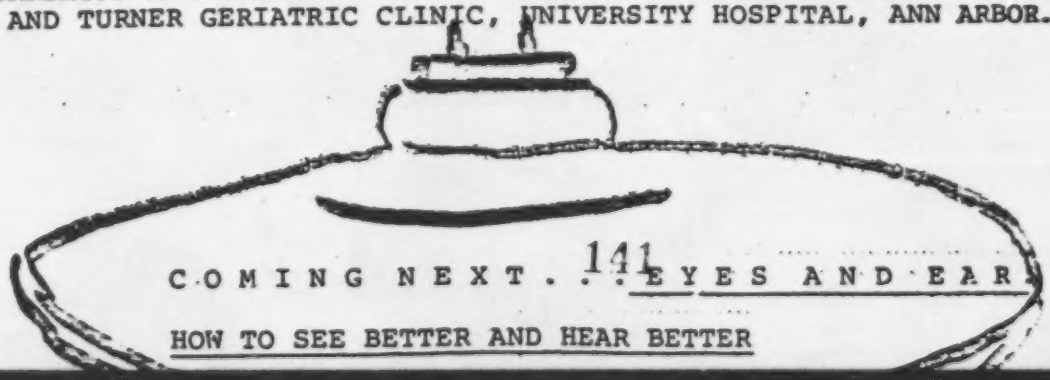
SPEAKER: LINDA STRODTMAN, R.N., M.S.

DIABETES RESEARCH AND TRAINING CENTER
UNIVERSITY HOSPITAL

WE WILL HAVE TIME FOR QUESTIONS TODAY BUT IF YOU THINK OF SOMETHING LATER YOU WOULD LIKE TO ASK, PLEASE TELL IT TO ONE OF THE PEER COUNSELORS**DAVE CRAWFORD, LYDIA HESS, ADDIE JONES, AUDREY LADOUCEUR, MARIE MOORE, EMMA OTTO, JOYCE WILLIAMS AND ADELLE WILSON***

WE APPRECIATE THE SUGGESTIONS AND COMMENTS YOU HAVE ON EACH WORKSHOP. THANK YOU FOR HELPING US MAKE THEM BETTER.

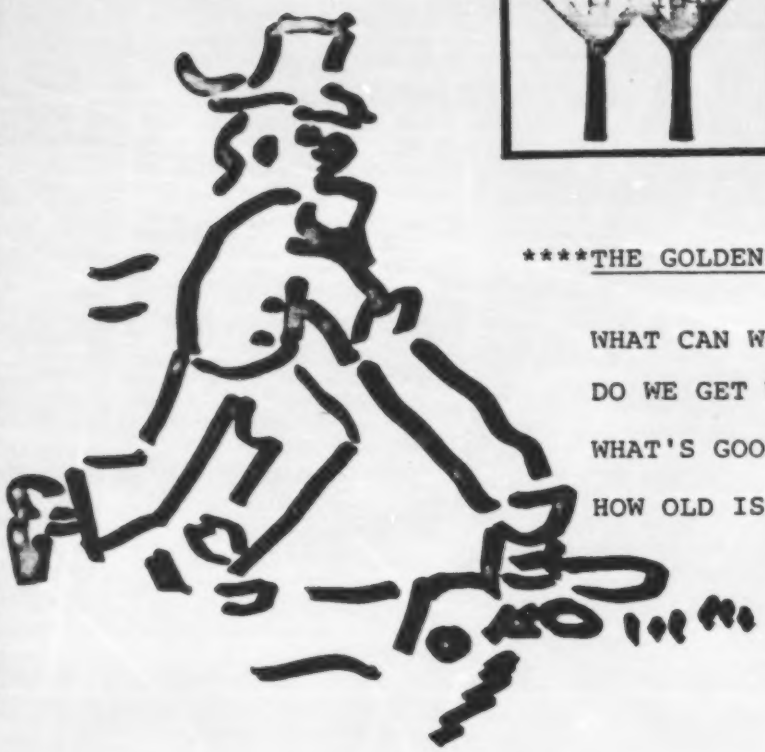
THESE WORKSHOPS ARE SPONSORED BY THE WASHTENAW COUNTY SENIOR NUTRITION PROGRAM AND TURNER GERIATRIC CLINIC, UNIVERSITY HOSPITAL, ANN ARBOR.



COMING NEXT . . . EYES AND EARS

HOW TO SEE BETTER AND HEAR BETTER

TURNER LEARNING PROGRAMS



****THE GOLDEN YEARS****

WHAT CAN WE EXPECT AS WE GROW OLDER?

DO WE GET WISER AS WE GET OLDER?

WHAT'S GOOD ABOUT GETTING OLD?

HOW OLD IS OLD?

DATE: FRIDAY, JUNE 27, 1980

TIME: 12:30 - 2:00 P.M.

PLACE: WILLOW RUN NUTRITION SITE
134 SPENCER LANE YPSILANTI

SPEAKER: MARVIE HACKNEY
UNIVERSITY OF MICHIGAN
INSTITUTE OF GERONTOLOGY

PANELISTS: DAVE CRAWFORD, ADDIE JONES
AUDREY LACOUCEUR, MARIE MOORE
BOB RAMSEY

NO ADMISSION FEE

CALL 483-8797 FOR MORE INFORMATION

SPONSORED BY:

TURNER GERIATRIC CLINIC
WASHTENAW COUNTY SENIOR NUTRITION PROGRAM
FUNDED BY THE ADMINISTRATION ON AGING

DRAWING BY JOYCE WILLIAMS

AN EMERGENCY FOOD BOX COULD SAVE YOUR LIFE

Bad weather or other problems can cut anyone off from the outside world.
Would you be prepared to feed yourself healthfully if you were temporarily homebound?

****

Some of the following food items should be stored in an "Emergency Box" in case you are unable to get out to shop because of a snow storm, power failure, sickness, etc.

-DRIED FRUITS SUCH AS RAISINS, DATES, FIGS, PEACHES APPLES, ETC.
-ANY CANNED FRUIT OR VEGETABLE, ESPECIALLY CITRUS OR TOMATO JUICE.

-DRIED* OR CANNED SOUPS
-DRY* DRINKS SUCH AS TANG

-CANNED MEATS, FISH AND POULTRY
-DRIED* MEAT STOCK

-PEANUTS AND OTHER NUTS
-PEANUT BUTTER
-DRIED* MILK
-CANNED MILK
-PROCESSED CHEESE FOOD THAD DOES NOT NEED REFRIDGERATION

-CRACKERS SUCH AS SALTINES AND GRAHAMS
-BREAD STICKS
-DRY CEREALS
-INSTANT* CEREALS

-JAM, JELLY, HONEY
-INSTANT COFFEE, TEA OR HOT CHOCOLATE*

OTHER ITEMS

-SMALL FLASHLIGHT WITH NEW BATTERIES
-MATCHES AND A FEW CANDLES
-CAN OPENER

*THESE ITEMS REQUIRE WATER WHICH WILL NOT BE AVAILABLE IN CASE PIPES FREEZE. SUPPLEMENT THESE WITH OTHER FOOD ALSO.

 By Montgomery Lew, Pharm.D

SLEEP WORKSHOP
March 15, 1979
Pharmacist's Advice on Taking Sleeping Medications

1. Try non-drug techniques before trying drugs to get to sleep.

2. Suggested times to take medications: 30 minutes to 1 hour before retiring.

3. Potential Side Effects of medications:
   prescription medications: "hang over" feeling, upset stomach; there is a slight chance to cause sore throat, fever mouth sores or skin rash (see #5).
   nonprescription medications: dry mouth, blurred vision, excitation.

---

1. Caution: These medications cause drowsiness; don't drive or operate machinery after taking medications.

2. Caution: Avoid taking sleeping medication and certain types of other medications at the same time. (i.e., alcohol or cough or cold medication containing anti-histamine.) Anti-histamine could cause increase in sedative effect. Consult with your pharmacist for assistance.

3. If sleeping medications produce dizziness, or upset your stomach, try taking it with a glass of milk or with some food.

4. Some medication may cause dry mouth, try sucking on hard sour candy (sugarless), ice chip or chew gum.

5. Contact the physician if you develop a sore throat, fever, mouth sores or skin rash.

6. Don't increase the dose or stop taking your medication without the advice of your physician, especially if you have been taking it for a long time.

7. Don't store medications at your bedside. Store them in the medicine cabinet, out of reach of children.

8. Don't smoke in bed after taking medications.

ELEVATORS FOR HOME USE SOURCES

Fold down platform wheelchair elevator

Rehabilation Equipment Inc.
175 E. 83rd. St.
New York, N. Y. 10028

$800.00

Doesn't specify if for straight staircase only

Wheelchair elevator

"Negotiates straights, curves, corners, spirals"
Easily installed

Developed in Switzerland

Price unknown

Available from Garaventa (Canada) Ltd.
7505 134A Street
Surrey
British Columbia, Canada
3W7B3

Person only elevators (no wheelchair):

1 person Inclinette - straight staircase "budget priced"

2 person Inclin-ator - " "

Available from Inclinator Co. of America
2200 Paxton St.
Harrisburg, Pa. 17111

1 person stair-slide - straight staircase

American Stairglide Corp.
1000 West 25th St.
Kansas City, Missouri 64108

$990.00

1 person Esca-Lift - Straight or curved or divided stairways

Dover Electric Corp.
Elevator Division
P. O. Box 2177
Memphis, Tenn. 38102

No price

Brochures available for most of above.

Barbara Burkhardt
Occupational Therapy
University Hospital

Q. I read recently that isometric exercises will help improve sagging and wrinkled skin and prevent the appearance of further undesirable changes. Is this true?

A. Aging skin in which wrinkles are present shows loss of normal elastic tissue and other degenerative changes. these cannot be reversed by exercise.

Q. I am a woman of fifty-five. I wish to prevent my skin from drying up and wrinkling. What special creams are recommended?

A. Most changes in the skin that we associate with aging, such as excessive dryness, wrinkling and spots of hyperpigmentation, are limited to exposed areas of the skin, and directly or indirectly are due to the ultraviolet rays of sunlight. Apart from avoiding sun exposure and using sun-protective creams at all times and in all places, beginning in childhood, nothing is known that will reverse such changes. The only benefit to aging skin that "rejuvenating" creams can provide regardless of the ingredients they claim to contaim, are temporary relief from dryness and temporary softening and smoothing of fine lines and rough skin.

Q. As I grow older, I have noticed the appearance of brown spots on the backs of my hands and on my face. What causes these spots, and can anything be done to make them go away? Are they dangerous.?

A. They are caused primarily by years of exposure to sun and wind, and the skin in these areas usually shows other evidence of sun damage. By the time the brown spots appear, the skin has been irreversibly damaged. Treatment consists of preventing further irritation. Sunbathing and extreme exposure to sunlight should be avoided, and a sun-protective cream should be used when exposure is unavoidable. Self diagnosis and treatment of pigmented spots is not recommended. Lesions of this type should be examined by a physician if they may indicate the presence of skin cancer, which may also develop on exposed skin. Physicians have several techniques available for removing such spots.

Q. I have been told that I should never wash my face with soap and water, that I should use a cleansing cream instead. Is this true?

A. Cleansing removes oily secretion, sweat, skin debris, dirt, cosmetics and a certain number of bacteria. It can be carried out most quickly and effectively with water and a mild soap or detergent. Normal as well as oily skin easily tolerates this treatment on a regular basis.

Q. What causes bags under the eyes?

A. Normally the skin of the eyelids is loosely attached. As a person grows older, some underlying tissues are lost and the lower lids tend to fall in folds. Plastic surgery is the only method that will improve this condition, cosmetics offer little aid

Q.I have broken blood vessels on my legs, what can I do to get rid of them?

A. These blemishes consist of timy dilated veins filled or congested with blood. They may appear as early as age thirty in areas of strain. Some believe that any practice or activity that makes it difficult for blood to circulate should be avoided.This includes tight garters, girdles, keeping legs crossed while sitting etc. A physician should be consulted if there is any discomfort or concern, or if broken blood vessels occur on the trunk of the body or on the face.

TURNER GERIATRIC CLINIC

1000 Wall Street
Telephone: 764-6831

SHOE SHOPS OFFERING RETREADING

COLLEGE SHOE REPAIR
607 East William Street
Ann Arbor
Telephone: 662-0400

Takes a Couple of Days
They offer different thicknesses of tread
Men's shoes - $6.25
Women's shoes - $5.25

*****

L & F SHOE REPAIR
207 South Ashley
Ann Arbor
Telephone: 769-9066

Takes two to three days
Tread is cemented on
Uses only one kind of tread
Men's shoes - $7.00
Women's shoes - $6.00

*****

STUDENT SHOE REPAIR
345 Maynard
Ann Arbor
Telephone: 662-9427

One day service
$5.00 flat rate for men and women

*****

CO-OP OPTICAL, 4633 Washtenaw, Telephone 434-3030

They have bifocal sunglasses

*****

AGENCIES OFFERING FREE SNOW REMOVAL

CUT 'N CARE
Telephone: 994-3500

No charge for seniors
Arrangements are made over phone

*****

SALVATION ARMY - Telephone: 668-8353

Chore referral service - Mrs. Parsa in charge.

They have a list of names and telephone numbers for the needy individual to make contact with

*****

NEIGHBORHOOD SENIOR SERVICE - Telephone: 662-4862

Have direct referral service to encourage independence of seniors.
No fee for snow removal for seniors--arrangements are worked out.
Reasonable price for those who can afford it.

TRANSPORTATION SERVICE FOR SENIORS

OUT-COUNTY DIAL-A-RIDE

Telephone: 971-4114

Serves Washtenaw County

Make reservations one day in advance - preferred.

Hours: 7:00 A.M. to 5:00 P.M.

Have lifts for wheelchair passengers.

TUESDAYS, FRIDAY AND SATURDAYS designated as SHOPPING DAYS

MONDAYS, WEDNESDAYS AND THURSDAYS designated as MEDICAL DAYS

FARE: Free to seniors -- underwritten by the Area Council on Aging.
They do ask for donations. 50¢ one way - Ann Arbor, Ypsilanti
$1.00 to Saline, if passenger can afford.

They provide door to door service

*****

ANN ARBOR COMMUNITY CENTER BUS

Telephone: 662-3120

Call a day or two in advance for an appointment. There is no charge.

MONDAY AND FRIDAY -- Medical Appointments

TUESDAY AND WEDNESDAY -- Senior Citizens Guild

THURSDAY -- Shopping Trips

DR. BARTON'S OUTLINE OF HELPFUL HINTS FOR MEMORY COURSE

Recognition of stress, anxiety, loss, depression:

not doing usual daily activities
change in sleep pattern (too little, too much)
change in appetite
confusion
fainting
automaton like
superstitiousness
jumpiness
crying jags
overwhelming waves of guilt
outbursts of anger
feelings of being shattered
loss of self respect
ruminating - what I should have done
going from one friend to the next with a tale of woe
use of alcohol increases
use of drugs - own, others
dizziness
giddiness
irritability
feelings of rejection
accident proneness
nightmares
fear of death, disease
doing busy work instead of main work
"I'm doing all I can"
denial - the world's all wrong, I'm all right

Ways to cope:

1. Plan for retirement
   - have interests beyond work
   - have friendships in different age categories
   - build up a nest egg
2. Plan for spouse's death
   - share knowledge about business
     - bank accounts
     - wills
     - papers
     - property
   - share knowledge about homemaking
     - cooking
     - cleaning
     - laundry
     - shopping
     - repair people
3. Rely on a network of people:

relatives	organizations
friends	Meals on Wheels
church	Senior Citizens
clubs	Dial-a-Ride, etc.

4. Constructive action decreases stress - just starting a project
5. Learn new skills
6. Call on your sense of humor
7. Practice sound nutrition
8. Practice good sleep habits
9. Look at past achievements
10. Learn a relaxation technique - yoga, self hypnosis, meditation, muscle relaxation
11. Have leisure activities
12. Stop excessive use of alcohol, drugs, tobacco, caffeine
13. Role play ahead a stress filled situation
14. Anticipate life changes
15. Pace yourself
16. Exercise moderately

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